

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/66

Item 2 Film G390 7/18/67 kk

09112

CERTIFICATE OF DEATH

09111

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baptist Home of Md.</b>		d. STREET ADDRESS <b>723 Gorsuch Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Carolyn</b> Middle <b>Adam</b> Last <b>Adam</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1871</b>
9. AGE (In years last birthday) yrs. <b>95</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dietician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joel O. Adam</b>		14. MOTHER'S MAIDEN NAME <b>Martha D. Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-34-9600</b>	
17. INFORMANT <b>Baptist Home of Md.</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior-elastic Cardiac - Vascular</b> <b>442X</b> DUE TO (b) <b>Renal Disease &amp; uremia</b> DUE TO (c) <b>old age</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>60</b> , to <b>July 9</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>July 9</b> , 19 <b>67</b> , and that death occurred at <b>7</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Paul Byerly</b>		22b. DATE SIGNED <b>7/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Paul Byerly</b>		22d. ADDRESS <b>5820 York Rd. Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-11-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1967</b>	
ADDRESS <b>6500 York Rd. 21212</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
091113					091112				
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk					b. COUNTY Baltimore				
c. LENGTH OF STAY IN 1b 13 Years					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2704 Gray Manor Court					d. STREET ADDRESS 2704 Gray Manor Court				
3. NAME OF DECEASED (Type or print) First Joseph Middle K. Last Airey					4. DATE OF DEATH Month July Day 6 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/27		9. AGE (In years last birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician - Donnelly		10b. KIND OF BUSINESS OR INDUSTRY Ad. Md. Advertising Corp.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph F. Airey					14. MOTHER'S MAIDEN NAME Adrianna Jenkins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-8048		17. INFORMANT (Wife) Mrs. Mary J. Airey, 2704 Gray Manor Ct.		Address Dundalk, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, metastatic</i> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Carcinoma of the lungs, primary</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March, 1967 to July, 1967, that (I) (we) last saw the deceased alive on June 30, 1967, and that death occurred at 9:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Benigno M. Oteyza</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/6/67			
22c. PHYSICIAN'S NAME (Type) Benigno M. Oteyza				22d. ADDRESS M. D. 1012 Old North Point Rd. Dundalk, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS		25a. REC'D BY REGISTRAR JUL 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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## CERTIFICATE OF DEATH

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09113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp</u>		d. STREET ADDRESS <u>3720 McDonough Road</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert S. Arbesman</u>		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed Home Improvement</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Rd.</u>	9. AGE (In years last birthday) <u>39</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>The Arbesman</u>		14. MOTHER'S MAIDEN NAME <u>Veretly Libbey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive Heart Failure</u> DUE TO (b) <u>SEVERE CORONARY HEART DISEASE</u> DUE TO (c) <u>ATHEROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>RECURRENT PULMONARY EMBOLi</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>67</u> , to <u>7-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-22</u> , 19 <u>67</u> , and that death occurred at <u>6:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba M.D.</u>		22b. DATE SIGNED <u>7-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Madamba</u>		22d. ADDRESS <u>Balto. Co. Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Roseville Md</u>
24. FUNERAL DIRECTOR <u>McGuire &amp; Bros. Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 26 1967</u>	
ADDRESS <u>601 E. Light</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

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FOR STATE  
HEALTH DEPT.

09115

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09114

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1624 Eastern Ave.</b>				d. STREET ADDRESS <b>1624 Eastern Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM VERNON ARCHER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1895</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William W. Archer</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Archer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>212 03 1079</b>		17. INFORMANT <b>A. Virginia Luckan 8749 Old Harford Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO <b>HCVI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Theo. C. Patterson</b>		M.D.		22. DATE SIGNED <b>7/10/67</b>			
EXAMINER'S NAME (Type) <b>Theo. C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222</b>		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/11/ 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home 1407 Eastern Ave.</b>				25a. REC'D BY REGISTRAR <b>JUL 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>	c. LENGTH OF STAY IN lb <b>2 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarm, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Villam Maria Rest Home Glenarm, Md.</b>		d. STREET ADDRESS <b>Glenarm Rd., Glenarm, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Sister M. <sup>First</sup> <sup>Middle</sup> <sup>Last</sup> Rapheline Backhaus</b>		4. DATE OF DEATH Month <b>7</b> Day <b>12</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-1882</b>
9. AGE (In years birth day) yrs. <b>85</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>12</b> Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Bernard Backhaus</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Punte</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>218-54-3905-1</b>		17. INFORMANT <b>Sr. M. Kathleen Glenarm, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central vascular occlusion</b> DUE TO (b) <b>Pulmonary edema secondary to</b> DUE TO (c) <b>Congestive heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>October 6, 1966</b> , to <b>July 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 6, 1967</b> , and that death occurred at <b>9:10 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Henry L. McCrindle</b>		22b. DATE SIGNED <b>7-13-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 15, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sisters Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Arm, Maryland</b>
24. FUNERAL DIRECTOR <b>Raymond J. Curran</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>817 Scarlett Dr. Towson, Maryland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

111

CERTIFICATE OF DEATH

111

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue, New York

William David Rose (Graham), No.

Bellevue, No., Graham, No.

Sister W. Anneline Graham

12 67

White

9-11-1900

85

Bellevue

Bellevue, No.

U. S. A.

Bellevue

Bellevue, No.

W. M. Graham, No.

210-1-1905-11

no

111



## CERTIFICATE OF DEATH

09117

09116

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>Baltimore - Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>3100 Cornwall Road #21222</b>			
3. NAME OF DECEASED (Type or print) <b>Joseph</b> <sup>First</sup> <b>Baby</b> <sup>Middle</sup> <b>John</b> <sup>Lost</sup> <b>Boy</b> <b>Bahorich Jr.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1967</b>	
				9. AGE (In years lost birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Joseph J. Bahorich</b>				14. MOTHER'S MAIDEN NAME <b>Carol Ann Grayson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (Father) <b>Joseph J. Bahorich, 3100 Cornwall Rd.</b> Address <b>Dundalk, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>752X</b> IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 2, 1967</b> to <b>July 2, 1967</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>July 2, 1967</b> , and that death occurred at <b>9:10 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Imelda B. Salanio</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Imelda B. Salanio, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a. REG. BY REGISTRAR <b>JUL 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Duda</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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091118

## CERTIFICATE OF DEATH

091117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethrope</u>		c. LENGTH OF STAY IN lb <u>40 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1706 Rittenhouse Ave.</u>		d. STREET ADDRESS <u>1706 Rittenhouse Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph F. Baker, Sr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-98</u>
9. AGE (In years, lost birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Helen Hass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-18-3916</u>	
17. INFORMANT <u>Helen Baker</u>		Address <u>1706 Rittenhouse Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthma</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>July 22</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 20</u> 19 <u>67</u> , and that death occurred at <u>7:00 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>A. Bradley Daugharthy</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. Bradley Daugharthy, M.D.</u>		22d. ADDRESS <u>1264 Francis Ave. 21227</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>July 25, 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Ambrose Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

1110

TESTIMONY OF DEATH

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JUL 17 1967

VR A15 (4)  
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09120

## CERTIFICATE OF DEATH

09119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY in 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b> d. STREET ADDRESS <b>Box 171</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JANE</b> f. SEX <b>F</b> g. COLOR OR RACE <b>Negro</b> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> i. AGE (In years last birthday) <b>86</b> j. IF UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>		4. DATE OF DEATH <b>7 14 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE MATTHEWS</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>SARAH REED</b> 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Records, Mount Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>4200</b> DUE TO (c) <b>20 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6.28.67</b> , 19 <b>67</b> , to <b>7.14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7.14</b> , 19 <b>67</b> , and that death occurred at <b>12:03</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b> 22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland</b>		22b. DATE SIGNED <b>7.14.1967</b> 22d. ADDRESS <b>Tarring Funeral Home, Aberdeen, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>17 July 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, (Har.) Md.</b>	
24. FUNERAL DIRECTOR <b>Walter Newcomer Jr.</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09121

CERTIFICATE OF DEATH

09120

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>42 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			d. STREET ADDRESS <b>1632 E. 31st STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>BARGET</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>1967</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/94</b>	9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Ooys Hours Min. <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AGENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>HENRY C. BARGET</b>		
14. MOTHER'S MAIDEN NAME <b>ELIZABETH ENGLAND</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		
16. SOCIAL SECURITY NO. <b>213 03 77 90</b>			17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL CARCINOMA OF THE PROSTATE</b> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) OUE TO (c) OUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis. Chronic Brain Syndrome due to Cerebral Arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DEATH MAY HAVE OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/11</b> , 19 <b>67</b> , to <b>7/23</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7/23</b> , 19 <b>67</b> , and that death occurred at <b>5:10</b> M, from causes and on the date stated above <b>A.</b>					
22a. SIGNATURE <b>Pushpendra Senan, M.D.</b>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>PUSHPENDRA SENAN, M.D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville Maryland</b>		
24. FUNERAL DIRECTOR <b>William Cook-Brooks Towson</b>		ADDRESS <b>1050 York Rd. Towson, Md.</b>	25a. REC'D BY REGISTRAR <b>JUL 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Generalized Ataxic Syndrome. Chronic Brain Syndrome due to Generalized Ataxic Syndrome.

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00121

## CERTIFICATE OF DEATH

09122

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CHESAPEAKE MANOR NURS. Home</b>		d. STREET ADDRESS <b>3010 W. COLD SPRING LAKE</b>	
3. NAME OF DECEASED (Type or print) <b>DORA M. BARTON</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 17, 1897</b>
9. AGE (In years) Last birthday <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>HEREFORD CO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>(unknown) MAYS</b>		14. MOTHER'S MAIDEN NAME <b>(unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>MRS IRENE B MITCHELL</b>		Address <b>Horseshoe Circle MD</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinoma sigmoid colon.</b> 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>7/21</b> , 19 <b>67</b> , to <b>7/21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/20</b> 19 <b>67</b> , and that death occurred at <b>940 PM</b> , from causes and on the date stated above.		
22a. SIGNATURE <b>Francois X. Carmody</b>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/21/67</b>
22c. PHYSICIAN'S NAME (Type) <b>FRANCOIS X CARMODY</b>	22d. ADDRESS <b>3201 N. CHARLES ST</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>
23d. LOCATION (City or Town) (County) (State) <b>Pikesville &amp; BALTO MD</b>		
25a. REC'D BY REGISTRAR <b>Loring Byers</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
25c. ADDRESS <b>8728 Liberty Rd Randallstown MD</b>		DATE <b>JUL 25 1967</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09123

CERTIFICATE OF DEATH

09122

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural...Baltimore</b>		c. LENGTH OF STAY IN 1b <b>13.1</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural...Baltimore</b>		d. STREET ADDRESS <b>3004 Texas Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3004 Texas Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Melford Wilford F. Baynes</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <b>Nov. 15, 1904.</b>
9. AGE (In years last birthday) yrs. <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machine Operator Western Elec. Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Baynes</b>		14. MOTHER'S MAIDEN NAME <b>Lillian ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>216-03-5724</b>	
17. INFORMANT <b>Mrs. Louise D. Baynes</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X Carcinoma of the prostate + metastases</b> DUE TO (b) <b>2 yrs +</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12.8</b> , 1964, to <b>7.2</b> , 1967, that (I) (we) last saw the deceased alive on <b>12-8-7-11</b> , 1967, and that death occurred at <b>11:52 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Joseph Skloven</b>		22b. DATE SIGNED <b>7.3.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Skloven</b>		22d. ADDRESS <b>7122 Harford Rd., Balto. Co., Md..21234</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/6/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc....Baltimore City, Md..14</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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ORIGINATOR'S NAME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09124

CERTIFICATE OF DEATH

09128

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN IB <b>33 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>5 N. ELLWOOD AVENUE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEE NMI BECHTOLD</b>				4. DATE OF DEATH Month Day Year <b>JULY 19, 19 67</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/7/89</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN BECHTOLD</b>				14. MOTHER'S MAIDEN NAME <b>MARY BENDORF</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>213 03 14 74</b>		17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>177 X</b> (b) <b>CARCINOMA OF PROSTATE WITH METASTASIS</b> (c) <b>ANEMIA</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (b) (this hospital) attended the deceased from <b>6/16/67</b> , 19 <b>67</b> , to <b>7/19/67</b> , 19 <b>67</b> , that (b) (we) last saw the deceased alive on <b>7/19/67</b> , 19 <b>67</b> , and that death occurred at <b>10:50 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Milton Ginsberg</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MORAN FUNERAL HOME</b> <b>BALTIMORE &amp; POTOMAC STREETS, BALTIMORE, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 24 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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09125

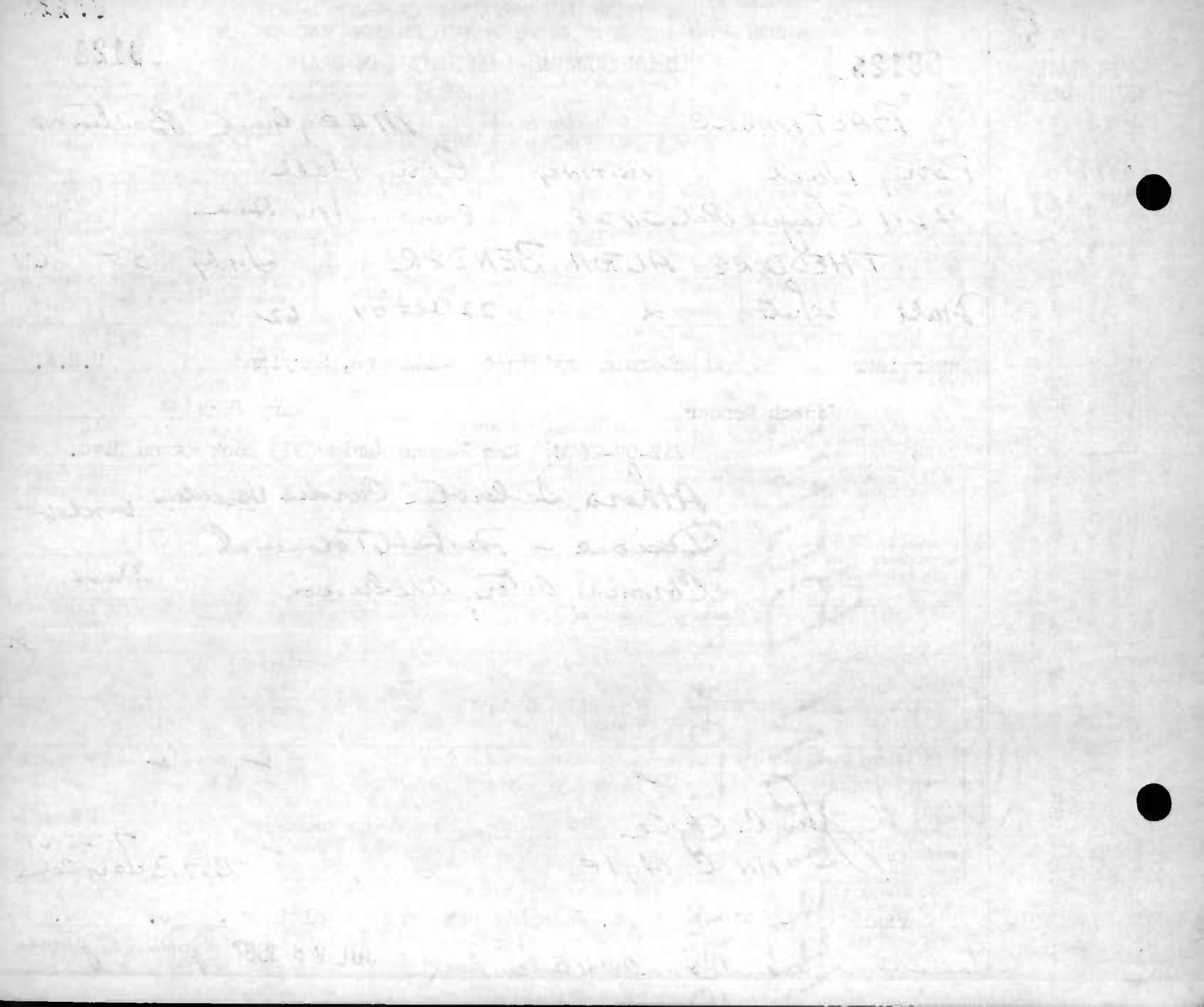
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09124

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. LENGTH OF STAY IN lb <u>VISITING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4211 Chapel Rd, 21128</u>		d. STREET ADDRESS <u>Cowenton Ave</u>	
3. NAME OF DECEASED (Type or print) <u>THEODORE ALTON BENDER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 Oct '04</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McCormic Aspiatuse</u>	9. AGE (In years last birthday) <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bender</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fuka</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-09-2670</u>	
17. INFORMANT <u>Mrs Jeanne Nerim</u>		Address <u>5913 Lock Raven Blvd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis Cardio Vascular</u> DUE TO <u>Dissection - Probable Terminal</u> DUE TO <u>Coronary Artery Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u> EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		22. DATE SIGNED <u>7-25-67</u> Address (Street, city, town, or county) <u>7527 Belair Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-28-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>
24. FUNERAL DIRECTOR <u>Lassalmt Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 28 1967</u>	
ADDRESS <u>7411 Belair Road</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jagger</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09126

09126

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN TB —	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>4421 Wilkens Ave. 21229</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4421 Wilkens Ave. 21229</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nils I. IVAR Berg</u>		4. DATE OF DEATH Month <u>29</u> Day <u>July</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/02</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	11. IF UNDER 24 HRS. Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mack Truck Co. Sweden</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>- - - Berg</u>		14. MOTHER'S MAIDEN NAME <u>- - -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-1462</u>	
17. INFORMANT <u>Mrs. Dorothea M. Burgoon, 1243 Leeds Terrace</u>		Address <u>21227</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>464X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Phlebitis - Thigh</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>1 month</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>A.S.C.V.D.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that (I) (the hospital) attended the deceased from <u>29 July, 1967</u> , to <u>29 July, 1967</u> , that (I) (the hospital) saw the deceased die on <u>29 July, 1967</u> and that death occurred at <u>—</u> M, from causes on the date stated above.			
22a. SIGNATURE <u>Ralph E. Updike MD</u>		22b. DATE SIGNED <u>30 July '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph E. Updike MD</u>		22d. ADDRESS <u>31 Dogwood Drive 21043</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore MD.</u>
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>AUG 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09127

CERTIFICATE OF DEATH

09126

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>03:1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>8147 Scots Level RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Berman</u> Last <u>Berman</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/90-</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hertza Youngman</u>		14. MOTHER'S MAIDEN NAME <u>Chava ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Sylvia Leventhal</u>		Address <u>8147 Scots Level Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insuff. &amp; Cong. Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardio Vas. Disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ca of Breast</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>67</u> , to <u>7-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> , 19 <u>67</u> , and that death occurred at <u>3:25</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Rolando A. Madambz</u>		22b. DATE SIGNED <u>July 12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Rolando A. Madambz</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beth Moses</u>		23d. LOCATION (City or Town) (County) (State) <u>Pinelawn Babylon, L.I., N. Y.</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1998

78190

## CERTIFICATE OF DEATH

09127

09128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY General Hospital</u>		d. STREET ADDRESS <u>4857 Reisterstown Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sadie</u> First Middle Last <u>BERMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/92</u> 74 yrs.
9. AGE (In years last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABRAHAM COOPER</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Perlman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>101-26-1126</u>	
17. INFORMANT <u>Mr. Abraham S. Berman, 6113 Stuart Avenue</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X</u> <u>Obtuse Bronchopneumonia</u> DUE TO (b) <u>② Parkinson's Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> , 19 <u>67</u> , to <u>7-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> AM, from causes on and on the date stated above.			
22a. SIGNATURE <u>D. Simon, M.D.</u>		22b. DATE SIGNED <u>7-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. SIMON</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>(Anshe Emenah) Aitz Chaim</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

10015

CONTRACT OF SALE

10015



10015

10015

10015



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09129

CERTIFICATE OF DEATH

09128

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE 03.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5533 LANHAM WAY</b>				d. STREET ADDRESS <b>5533 LANHAM WAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET B. BETZ</b>				4. DATE OF DEATH <b>JULY 13 1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/28/1890</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>MICHAEL FAHEY</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Address</b> <b>CATHERINE KING ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbo V Gasoline Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>July</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>7/12/67</b> 19____, and that death occurred at <b>9:25</b> P.M. from causes and on the date stated above.							
22a. SIGNATURE <b>R J Lyden M.D.</b>				22b. DATE SIGNED <b>7/14/67</b>		22c. PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN M.D.</b>	
22d. ADDRESS <b>6402 GOLDEN RING Rd. 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>ADDRESS</b> <b>CONNELLY SONS 300 MACE</b>				25a. REC'D BY REGISTRAR <b>JUL 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

29132

1961

CENTRAL OF DEATH

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09129	
09130					
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>48 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>604 Reservoir Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>LINCOLN</b> Last <b>BILLIPS, JR.</b>			4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/30/24</b>	9. AGE (In years last birthday) yrs. <b>43</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Chesterfield Co., Va.</b>	
13. FATHER'S NAME <b>George L. Billips</b>			14. MOTHER'S MAIDEN NAME <b>Mammie Merritt</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW-11</b>		16. SOCIAL SECURITY NO. <b>223 22 53 33</b>		17. INFORMANT <b>Clinical Rcds VA Hospital Fort Howard, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>150X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY ABSCESSSES, MULTIPLE BRONCHOPNEUMONIA</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/6/</b> , 19 <b>67</b> , to <b>7/24</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7/24/</b> 19 <b>67</b> , and that death occurred at <b>11:50</b> from causes and on the date stated above.					
22a. SIGNATURE <b>J. D. Talbert</b>			22b. DATE SIGNED <b>am</b>		22c. PHYSICIAN'S NAME (Type) <b>VA Hospital, Fort Howard, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FAMILY BURIAL GROUND CHESTERFIELD COUNTY, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>Wilkerson Funeral Home</b>		ADDRESS <b>Petersburg, Va.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 27 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09138

Reg. Dist. No.

FOR STATE  
HEALTH DEPT

09131

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks Pt - 19</b> c. LENGTH OF STAY IN 1b <b>20.4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harbor Mt Pleasure Club</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1835 Freedom Way</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kathleen</b> Middle <b>Antoinette</b> Last <b>Blair</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9th.</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1956</b>
9. AGE (In years last birthday) <b>10 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Oscar Ell Blair</b>		14. MOTHER'S MAIDEN NAME <b>Adelia Gregory</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Oscar Ell Blair, 1835 Freedom Way</b>		Address <b>1835 Freedom Way</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> DUE TO <b>9298</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>While at work</b> DUE TO (c) <b>Not while at work</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <b>Chipped from bar with deep water</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Chipped from bar with deep water</b>	
20c. TIME OF INJURY Month, Day, Year <b>7-9-67</b> Hour <b>2:00</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ches. Bay</b>		20f. CITY OR TOWN (County) (State) <b>Sparks Pt - Baltimore Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		DATE SIGNED <b>7/10/67</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
<b>5800 Morningside Rd.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b>		<b>DEPUTY MEDICAL EXAMINER</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Vernon Lannon</b>		ADDRESS <b>4611 Park Heights Av. Balto.</b>	
24a. REC'D BY REGISTRAR <b>JUL 11 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1992



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09132

CERTIFICATE OF DEATH

09131

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN lb <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		d. STREET ADDRESS <u>10318 Malcolm circle</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>P.</u> Middle <u>Bond</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-00</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boys Scouts Inc</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boys Scouts Inc</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Southern Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>Francis Parrain Bond</u>			
14. MOTHER'S MAIDEN NAME <u>Magill, ESSIE</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>2 8705-0821</u>				17. INFORMANT <u>Patients chart.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> , to <u>July 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> 19 <u>67</u> , and that death occurred at <u>1:50 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Richard Krangel</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>C. Richard Krangel</u>	
22d. ADDRESS				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkville Md.</u>	
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson</u>				25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	

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REMARKS ON REAR

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

09133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09132

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>340 George Avenue</b>				d. STREET ADDRESS <b>340 George Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOUIS STEVE BORSOS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1923</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Borsos</b>				14. MOTHER'S MAIDEN NAME <b>Esther Lukacs</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218 18 1878</b>		17. INFORMANT <b>Julius Borsos</b> Address <b>411 Lorraine Ave Balto 21, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>				22. DATE SIGNED <b>July 17, 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Brzezinski Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JUL 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS <b>1407 Eastern Ave. 21</b>							

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Dec. 11, 1963

USA

Radio Co., W.

Radio Co., W.

Radio Co., W.

Radio Co., W.

Radio Co., W.

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Baltimore Co., W.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

<div> <div>1</div> <div>09133</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>09133</div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> c. LENGTH OF STAY IN 1b <u>60yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>York Rd.</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> d. STREET ADDRESS <u>York Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emory August Borneman</u> First Middle Last <b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 15, 1892</u> <b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>19</u> Min. <u>67</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machinist</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tools</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore G. Md</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>									
<b>13. FATHER'S NAME</b> <u>Phillip Borneman</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Nannie Pearce</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>213-03-0032</u> <b>17. INFORMANT</b> <u>Thelma F. Borneman</u> Address <u>Parkton, Md</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.I.S.C.V. disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>A. M. F. France</u> M.D. <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>A. M. FRANCE</u> Address (Street, city, town, or county) <b>22. DATE SIGNED</b> <u>7/16/67</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>7-18-67</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Clynnmaryia Cem</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Monkton, Md.</u> <b>24. FUNERAL DIRECTOR</b> <u>Decol Hartenstein, New Freedom, Pa.</u> ADDRESS <u>NEW FREEDOM, PA.</u> <b>25a. REC'D BY REGISTRAR</b> <u>JUL 19 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. J...</u>									

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09135

## CERTIFICATE OF DEATH

09134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>BALTIMORE, MARYLAND 3-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE CO. GEN. HOSP.</u>		d. STREET ADDRESS <u>8042 LIBERTY RD</u>	
3. NAME OF DECEASED (Type or print) <u>DOROTHY CAROLYN BOVETTE</u>		4. DATE OF DEATH <u>7 31 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/26/00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESLADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT STORE MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>LOREY (EFFIE)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>220-24-3714</u>	
17. INFORMANT <u>Edward H. Holland</u>		Address <u>3725 Coronado Rd Baltimore Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral confluent Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>491X</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diffuse pulmonary edema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Weinfredo N. Iglesias</u>		22b. DATE SIGNED <u>8/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WEINFREDO IGLESIA</u>		22d. ADDRESS <u>Balti. Co. Gen Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Balt. Md</u>
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8728 Liberty Rd Randallstown</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 3 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
09136 Item #8 Film #G391 7/31/67 pm 09135													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6825 Blenheim Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b> d. STREET ADDRESS <b>6825 Blenheim Road 12</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith Linda Brockie</b>						4. DATE OF DEATH Month Day Year <b>July 24, 19 67</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1878</b> <b>10/17/1888</b>		9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - dressmaker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>			
13. FATHER'S NAME <b>James</b>						14. MOTHER'S MAIDEN NAME <b>Mary Husband</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Janet Brockie Box 13 Hazlet, N. J.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinoma of ovary</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month Day Year Hour a.m. <b>11</b> p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <b>she</b> (this hospital) attended the deceased from <b>1958</b> to <b>7/24, 1967</b> , that <b>he</b> (we) last saw the deceased alive on <b>July 11, 1967</b> and that death occurred at <b>AM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>William F. Renner</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>William F. Renner</b>						22d. ADDRESS <b>3222 St Paul St, Balto. Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>7/26/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickman &amp; Sons</b> <b>Baltimore Md</b>						25a. REC'D BY REGISTRAR <b>JUL 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09137

CERTIFICATE OF DEATH

09136

1. PLACE OF DEATH <i>SPRING GROVE S. Hospital</i> a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrod Grace Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SPRING GROVE State Hospital</i>				d. STREET ADDRESS <i>131 S. Stokes St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED <i>BULLOCK</i> First <i>FANNIE</i> Middle Last				4. DATE OF DEATH <i>7</i> Month <i>1</i> Day <i>67</i> Year <i>19</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/8</i>	9. AGE (In years last birthday) yrs. <i>78</i>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Manchester - England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Simon Greenberg</i>			14. MOTHER'S MAIDEN NAME <i>Lena Schnaer</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Unknown</i>			16. SOCIAL SECURITY NO. <i>217-14-6859</i>		17. INFORMANT <i>Daughter Mrs Anita Hanline</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO <i>Myocardial infarction</i> (b) <i>Generalized arteriosclerosis heart disease</i> DUE TO <i>Generalized arteriosclerosis heart disease</i> (c) <i>Generalized arteriosclerosis heart disease</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Elderly woman</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>NONE</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3/17/67</i> , 19 <i>67</i> , to <i>7/1/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/1/67</i> , 19 <i>67</i> , and that death occurred at <i>9:30</i> AM, from causes and on the date stated above.							
22a. SIGNATURE <i>Evelio A. Felipe</i>			22b. DATE SIGNED <i>7/1/67</i>			22c. PHYSICIAN'S NAME (Type) <i>EVELIO A. Felipe</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>July 3, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rudomer Verein</i>		23d. LOCATION (City or Town) (County) (State) <i>Rosedale, Maryland</i>
24. FUNERAL DIRECTOR <i>Sol Levinson &amp; Brso Inc. 6010 Reisterstown Rd.</i>				25a. REC'D BY REGISTRAR <i>JUL 5 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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MEMO TO DIRECTOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09137

09138

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>7 Wks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>421 E. 20th Street #21218</b>	
3. NAME OF DECEASED (Type or print) <b>Ellison B. Burch</b>		4. DATE OF DEATH <b>July 16, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-27-11</b>
9. AGE (In years lost birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Minister</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John A. Burch</b>		14. MOTHER'S MAIDEN NAME <b>Viola Harris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-202844</b>	
17. INFORMANT <b>William M. Coy - Boston, Mass.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>150X</b> DUE TO <b>Massive intra-tracheal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fistulous tract between trachea, esophagus and aorta</b> (c) <b>Carcinoma of the esophagus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>5-25-</b> , 1967, to <b>7-16-</b> , 1967, that (H) (we) last saw the deceased alive on <b>July 16,</b> 1967, and that death occurred at <b>8:15 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence Misanik M.D.</b>		22b. DATE SIGNED <b>July 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Misanik M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/23/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Franklin</b>		23d. LOCATION (City or Town) (County) (State) <b>Towson, S. C.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Chatman</b>		25. REGISTRY REGISTRAR <b>Jul 20 1967</b>	
26. REGISTRAR'S SIGNATURE <b>Butler</b>		27. REGISTRAR'S SIGNATURE <b>Butler</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09138

CERTIFICATE OF DEATH

09138

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b>		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b>		First <b>E.</b>		Last <b>Burk</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19,</b> Year <b>19 67</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 29, 1882</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Amrein</b>		14. MOTHER'S MAIDEN NAME <b>Margaret ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 07 2713</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute posterior septal myocardial infarction</b> DUE TO (b) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary thrombo-embolism</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(this hospital)</b> attended the deceased from <b>July 2,</b> 19 <b>67,</b> to <b>July 19,</b> 19 <b>67,</b> that <b>(we)</b> last saw the deceased alive on <b>July 19,</b> 19 <b>67,</b> and that death occurred at <b>3:20AM,</b> from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 19, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 22, 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Blenheim</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Win. Cook-Brooks Towson, Towson, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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## FOOTNOTES

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7. SE 105

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09140

CERTIFICATE OF DEATH

09138

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>Baltimore 21212</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1441 Meridene Dr.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eldridge Price Burns</b>				4. DATE OF DEATH Month Day Year <b>July 24, 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1890</b>		9. AGE (In years lost birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Optician</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>197-01-6047</b>		17. INFORMANT Address <b>Mrs Hazel Burns 1441 Meridene Rd. Balto.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Atherosclerosis generalized severe</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anemia, microcytic and hypochromic. Secondary to G.I. Bleeding</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 24, 1967</b> , to <b>July 24, 1967</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>July 24, 1967</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Manuel S. Cockburn</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Manuel S. Cockburn, M.D.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Witzke 4101 Edmondson Ave Balto. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 27 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Guiggi</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

001324

COMMUNICATIONS SECTION

001324

1000-1015

1015-1030

1030-1045

1045-1100

1100-1115

1115-1130 1130-1145 1145-1160 1160-1175 1175-1190 1190-1205 1205-1220 1220-1235 1235-1250 1250-1265 1265-1280 1280-1295 1295-1310 1310-1325 1325-1340 1340-1355 1355-1370 1370-1385 1385-1400 1400-1415 1415-1430 1430-1445 1445-1460 1460-1475 1475-1490 1490-1505 1505-1520 1520-1535 1535-1550 1550-1565 1565-1580 1580-1595 1595-1610 1610-1625 1625-1640 1640-1655 1655-1670 1670-1685 1685-1700 1700-1715 1715-1730 1730-1745 1745-1760 1760-1775 1775-1790 1790-1805 1805-1820 1820-1835 1835-1850 1850-1865 1865-1880 1880-1895 1895-1910 1910-1925 1925-1940 1940-1955 1955-1970 1970-1985 1985-2000

1970-1985 1985-2000

1985-2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 3, 13, 14 Film  
 3408 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 09141 1/10/69 jmj  
 CERTIFICATE OF DEATH  
 09140

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>		c. LENGTH OF STAY IN b. <u>3 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>2732 Baker Street</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bent Nursing Home Baltimore Maryland</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Joseph</u> Last <u>BUTLER</u>				4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>19 67</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12-1899</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvador</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Butler</u>				14. MOTHER'S MAIDEN NAME <u>Alice Butler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Elva Caldwell</u>		Address <u>2732 Baker St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>July 1967</u> , that (I) (we) last saw the deceased alive on <u>7/2/67</u> , 19 <u>67</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip Bernstein</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP BERNSTEIN</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert &amp; Cyeth 1701 Laurens</u>				25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
09142		CERTIFICATE OF DEATH	
09141			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Maryland 21204</b>	
c. LENGTH OF STAY IN 1b <b>1yr. 26days</b>		d. STREET ADDRESS <b>114 Edgewood Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>H.</b> Last <b>Callender</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-78</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Isaac Hallick</b>		14. MOTHER'S MAIDEN NAME <b>Emma East</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>383-09-6910</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>465X Pulmonary emboli</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 6, 1967</b> to <b>July 5, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 5, 1967</b> , and that death occurred at <b>1:05</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>7-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>7/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>1050 York Rd.</b>		25a. REC'D BY REGISTRAR <b>JUL 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>		DATE	
Wm. Cook-Brooks Towson Inc. Towson, Md. 21204			

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CERTIFICATE OF DEATH

09143

09142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Baltimore</b>		c. LENGTH OF STAY IN lb <b>41 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brightside Road</b>				d. STREET ADDRESS <b>Brightside Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Fitts Carey</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>19 67</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-1898</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edwin A. Fitts</b>				14. MOTHER'S MAIDEN NAME <b>Louise MacDonald</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-48-8779</b>		17. INFORMANT <b>G. Cheston Carey</b>		Address <b>Above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastases</b> DUE TO (b) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 22, 1965</b> , to <b>July 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 8, 1967</b> , and that death occurred at <b>12:30 A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>L. Myrton Gaines</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. Myrton Gaines</b>				22d. ADDRESS <b>7800 York Rd., Towson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-11-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. This certificate should be filed with the State Dept. of Health.

<div>1</div> <div>09144</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>09143</div>										
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>8036 Old Chula Rd</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8036 Old Chula Rd</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> d. STREET ADDRESS <u>8036 Old Chula Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Louise A. Carman</u> First Middle Last					4. DATE OF DEATH <u>July 4</u> 19 <u>67</u> Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14 1911</u>		9. AGE (In years last birthday) <u>55</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Wm Ullrich</u>					14. MOTHER'S MAIDEN NAME <u>Hanna Burger</u>					
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Husband</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma ovary</u> DUE TO (c) <u>Papillary adenocarcinoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> , 19 <u>65</u> , to <u>7/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> , 19 <u>67</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>S.A. Alessi</u>					22b. DATE SIGNED <u>7/6/67</u>		22c. PHYSICIAN'S NAME (Type) <u>S.A. Alessi M.D.</u>			
23a. BURIAL, CREMATION, REMOVE (Specify)					23b. DATE THEREOF <u>7/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION (City, town or county) (State) <u>Balto</u>	
24. FUNERAL DIRECTOR <u>Chasemann</u>					25a. REC'D BY REGISTRAR <u>JUL 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. [unclear]</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09145

## CERTIFICATE OF DEATH

09145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>14r. 7 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Masonic Home</u>		d. STREET ADDRESS <u>5311 Jaylor Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Selva Chambers</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-1886</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas McHenry</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Cawings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-20-9470</u>	
17. INFORMANT <u>Md. Masonic Home Records</u>		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Vascular</u> <u>331X</u> DUE TO <u>Remontage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Hypertension</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 1965, to <u>July 28</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 28</u> , 1967, and that death occurred at <u>4:25</u> A.M., from causes and on the date stated above.	
22a. SIGNATURE <u>JAMES H. HAMED, M.D.</u>		22b. DATE SIGNED <u>7/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED, M.D.</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson T050 York Rd. 21203</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09146

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>10wson</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #21236</b> d. STREET ADDRESS <b>4502 Fullerton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Adrian M. Chandler</b>		4. DATE OF DEATH Month Day Year <b>July 4 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1908</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ackerman &amp; Baynes</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Onancock, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilbert M. Chandler</b>		14. MOTHER'S MAIDEN NAME <b>Minnie C. White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>228-01-8843</b>	
17. INFORMANT <b>Sue B. Chandler</b>		Address <b>4502 Fullerton Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease.</b> (c) <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 3</b> , 19 <b>67</b> , to <b>July 4</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>July 4</b> 19 <b>67</b> , and that death occurred at <b>11:45 PM</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>M. S. Cockburn</b>		22b. DATE SIGNED <b>July 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 8 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Taylor Ave Balto Md</b>	
24. FUNERAL DIRECTOR <b>The Dippel Brothers Inc</b>		25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>	
ADDRESS <b>7110 Belair Road</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09147		09147	
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN It <u>2 months 21 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE #7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSP</u>		d. STREET ADDRESS <u>910 MASEFIELD ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA</u> <u>CHIARAMONTE</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>15</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAUS.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>ITALIAN</u>	
13. FATHER'S NAME <u>SAVERIO PARINELLO</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGETT PANICOLA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-54-2982</u>	
17. INFORMANT <u>Mrs. Beatrice MANELLI</u>		Address <u>910 Masefield Rd, Balt.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>NONE.</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> , 19 <u>67</u> , to <u>7/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/15</u> , 19 <u>67</u> , and that death occurred at <u>9</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Vicente M. Ruano MD</u>		22b. DATE SIGNED <u>7-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vicente M Ruano</u>		22d. ADDRESS <u>Spring Grove Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-18-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Frank DellaVee</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>322 S. High St</u>		DATE <u>JUL 17 1967</u>	



09148

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		d. STREET ADDRESS <u>2808 Ulman Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie P. Cohen</u>		4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>80</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Partner, Mendel T.</u>		14. MOTHER'S MAIDEN NAME <u>Fruma ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. ASCVD with Congestive</u> 260X DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Diabetes Mellitus with Diabetic</u> (c) <u>stroke</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-27</u> , 19 <u>67</u> , to <u>7-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> , 19 <u>67</u> , and that death occurred at <u>1250 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. Simon</u>		22b. DATE SIGNED <u>7-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. Simon</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shaarei Zion</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bns. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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CERTIFICATE OF DATA

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09149		09149	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN lb <b>Baltimore 21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8208 Harford Road</b>		d. STREET ADDRESS <b>8208 Harford Road</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>V.</b> Last <b>COLE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1893.</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>27</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Whelan</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Manuel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-7506</b>	
17. INFORMANT <b>Mr. Elmer L. Cole, Sr.</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>Carcinoma of Rectum.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4pm 27 July, 1967</b> , to <b>8:30 27 July 1967</b> , that (I) (we) lost saw the deceased alive on <b>27 July 1967</b> , and that death occurred at <b>8:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John C. Hyle</b>		22b. DATE SIGNED <b>7-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>		22d. ADDRESS <b>7527 Belair Rd Baltimore Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/31/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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VR A15 (4)  
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## 09159

1. PLACE OF DEATH a. COUNTY <b>CHARLES COLLARS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>12/22/1967 - 7/19/1967</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CATON RIDGE NURSING HOME</b>		e. STREET ADDRESS <b>1237 Vogt Ave. 327 Harlem Lane</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES E. COLLARS</b>		4. DATE OF DEATH <b>7-19-1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>91 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Augustus Collars</b>		14. MOTHER'S MAIDEN NAME <b>Laura Virginia ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-0721</b>	
17. INFORMANT <b>Miss H. L. Parke</b>		Address <b>503 Title Building</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable Congestive Heart Failure</b> DUE TO (b) <b>ASCVD</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-7-1967</b> to <b>7-19-1967</b> , that (I) (we) last saw the deceased alive on <b>7-19-1967</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Cesar Valle Cauero</b>		22b. DATE SIGNED <b>7-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAUERO</b>		22d. ADDRESS <b>8629 Liberty Rd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/22/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Tubman &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>JUL 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

CERTIFICATE OF DEATH

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09151

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLIE</b> Middle <b>ROBERT</b> Last <b>CONGO</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1923</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Glamorgan, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tony Congo</b>		14. MOTHER'S MAIDEN NAME <b>Euney Tomko</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-11</b>		16. SOCIAL SECURITY NO. <b>223 26 38 39</b>	
17. INFORMANT <b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE GALL BLADDER, PROBABLE</b> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ACUTE PANCREATIC NECROSIS, RECENT. PORTAL CIRRHOSIS, LIVER</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>7/8/</b> 19 <b>67</b> , to <b>7/8/</b> 19 <b>67</b> that <del>he</del> (we) last saw the deceased alive on <b>7/8/</b> 19 <b>67</b> , and that death occurred at <b>11:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>7/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-12-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Smith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wise Virginia</b>	
24. FUNERAL DIRECTOR <b>John R. Slack</b>		25a. REC'D BY REGISTRAR <b>Higinbotham Slack Funeral Home</b> DATE <b>JUL 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

STATEMENT OF DEATH

1913

WOMAN'S HOSPITAL, NEW YORK  
JANUARY 1, 1913  
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JANUARY 1, 1913

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WOMAN'S HOSPITAL, NEW YORK  
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JANUARY 1, 1913  
JANUARY 1, 1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09152

09152

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		d. STREET ADDRESS <u>127 Warwick Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>127 Warwick Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>E.</u> Middle <u>Conrad</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1913</u>
9. AGE (In years lost birthday) yrs. <u>53</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mutual Clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Conrad</u>		14. MOTHER'S MAIDEN NAME <u>May Heil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-07-4210</u>	
17. INFORMANT <u>Mrs. Catherine Conrad same as 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4201</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work or work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/11, 1908</u> to <u>7/2, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/2, 1967</u> , and that death occurred at <u>7/2, 1967</u> M, from causes and on the date stated above.		22. SIGNATURE <u>Charles F. Donnell</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22a. PHYSICIAN'S NAME (Type) <u>Charles F. Donnell</u> 22b. DATE SIGNED <u>7/5/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204</u>		25b. REGISTRAR'S SIGNATURE <u>Charles F. Donnell</u>	

STATE OF TEXAS

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County of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one case, within 72 hours after death.

VR A15 (4)  
25M 1/67

SHIPPED TO: BECK & DOUGHERTY FUNERAL HOME, NEWPORTVILLE RD., LEVITTOWN, PA.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09153

CERTIFICATE OF DEATH

09153

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>170 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>C.</b> Last <b>CONROY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 24, 1920</b>
9. AGE (In years last birthday) yrs. <b>47</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYMENT INTERVIEWER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MAUCH CHUNK, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLETUS EUGENE CONROY</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE FREDERICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>201 07 30 13</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>CYSTADENOCARCINOMA RIGHT OVARY WITH WIDESPREAD METASTASIS</b> (c) <b>HYDRONEPHROSIS, BILATERAL</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>/</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/18/67</b> , 19__, to <b>7/7/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7/7/67</b> , 19__, and that death occurred at <b>8:50AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Milton Ginsberg</b>		22b. DATE SIGNED <b>7/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>7/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL &amp; PETER CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>LEHIGHTON, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR <b>Joseph N. Zannino</b>		25a. REG. BY REGISTRAR <b>JUL 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUL 14 1967</b>	
25d. ADDRESS <b>257 S. CONKLING ST. BALTIMORE, MD.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09154

CERTIFICATE OF DEATH

09154

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>30-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shady Nook Nursing Home</b>		d. STREET ADDRESS <b>2215 Ashton St. 21223</b>	
3. NAME OF DECEASED (Type or print) <b>Mina</b> First Middle Last		4. DATE OF DEATH <b>July 3 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/93</b>
9. AGE (In years lost birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Rider</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine - - -</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-12-8112</b>		17. INFORMANT Address <b>Mr. Alvin L. Leroy One Oak Place 21218</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic sclerotic heart disease</b> DUE TO (c) <b>90 an-</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour "a.m. "p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>67</b> , to <b>July 3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 2</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Wetherbee Ford</b>		22b. DATE SIGNED <b>July 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wetherbee Ford</b>		22d. ADDRESS <b>600 Patton Ave - Catonsville 28</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>	
25b. SIGNATURE <b>John S. Judge</b>		25c. ADDRESS <b>John S. Judge</b>	

1915

DEPARTMENT OF WAR

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Item 23B Film G391 7/26/67 kk

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN <b>16 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2209 Rockwell Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>J. WILSON CORWIN</b>				4. DATE OF DEATH <b>JULY 14 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/18/1900</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Administrator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospitals</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Daniel J. Corwin</b>			
14. MOTHER'S MAIDEN NAME <b>Florence Wilson</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>215-22-38-53</b>				17. INFORMANT <b>Clin.Rec. VA Hospital, Fort Howard, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>451X</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>ACUTE HEMORRHAGIC PANCREATITIS, POST-OPERATIVE</b> DUE TO (c) <b>ANEURYSM OF ABDOMINAL AORTA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>30 HOURS</b> <b>1 1/2 YEARS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>June 28, 1967</b> to <b>July 14, 1967</b> , that <b>we</b> last saw the deceased alive on <b>July 14, 1967</b> , and that death occurred at <b>10:15 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Madhav D. Barhanpurkar, M.D.</b>				22b. DATE SIGNED <b>7/15/67</b>		22c. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M.D.</b>	
22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>7-19-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>MacNabb Funeral Home</b>	
25a. REC'D BY REGISTRAR <b>JUL 20 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			

0270

U.S. GPO: 1967 O-345-745

1

Albert J. Cohen

1. **Formal**      2. **Informal**      3. **Unofficial**

• • • • •



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09156

CERTIFICATE OF DEATH

09156

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>103-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>		d. STREET ADDRESS <u>514 HILTON AVE</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES H. COSTIN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/95</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. H. R. R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HENRY COSTIN</u>		14. MOTHER'S MARDEN NAME <u>SARAH TURNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>205105443</u>	
17. INFORMANT <u>MRS. JAMES MIDDLETON</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate Gland</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8 May, 1967</u> to <u>12 July, 1967</u> , that (I) (we) last saw the deceased alive on <u>12 July 1967</u> , and that death occurred at <u>3:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>W. K. Gallap, Jr.</u>		22b. DATE SIGNED <u>12 July 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>		23d. LOCATION (City or Town) (County) (State) <u>CENTERVILLE, MD.</u>	
24. FUNERAL DIRECTOR <u>E.S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>301 FREDERICK RD. 21228</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 17 1967</u>	

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RECEIVED BY CLERK

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "CLERK" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 2 See birth cert. ans											
09157 CERTIFICATE OF DEATH 09157											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN lb <b>less than 1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			30.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>					d. STREET ADDRESS <b>5217 Frankford Ave. 21206</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby</b>					4. DATE OF DEATH Month <b>7</b> Day <b>12</b> Year <b>19 67</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/12/67</b>		9. AGE (In years lost birthday) yrs. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Edward James Crafts</b>					14. MOTHER'S MAIDEN NAME <b>Karin Christa Probst</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Maternal History</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7625</b> IMMEDIATE CAUSE (a) <b>Neonatal apnea and atelectasis</b> DUE TO (b) <b>Immaturity (800 gms.)</b> DUE TO (c) <b>stating the underlying cause lost.</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>7/12</b> , 19 <b>67</b> , to <b>7/12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> , 19 <b>67</b> , and that death occurred at <b>6:45 pm.</b> from causes and on the date stated above.											
22a. SIGNATURE <b>John E. Adams</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/13/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>John E. Adams, M.D.</b>					22d. ADDRESS <b>Greater Baltimore Medical Center</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Maryland</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>					25a. REC'D BY REGISTRAR <b>JUL 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>				

1010

CONTRACT NO. 1010

1010



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Parkton</b> c. LENGTH OF STAY IN lb <b>minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harris Mill Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkton</b> d. STREET ADDRESS <b>York Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES SAMUEL CUMMINGS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept 21, 1935</b>
9. AGE (In years lost birthday) yrs. <b>31</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, then if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>White Hall, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter J. Cummings</b>		14. MOTHER'S MAIDEN NAME <b>Irene McCarthy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes - 1956-1958</b>		16. SOCIAL SECURITY NO. <b>216-30-0213</b>	
17. INFORMANT <b>Walter Cummings</b>		Address <b>Parkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of Stomach Contents complicating</b> <b>8234</b> <del>Cerebral Injury</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subj. driving - car ran off road and flipped over</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:00 a.m. July 19, '67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Baltimore, MD</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>7/20/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Middletown Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Freeland, Md.</b>	
24. FUNERAL DIRECTOR <b>Isaac Hartenstein</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>New Freedom, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JUL 24 1967</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23b & c Film #G391 8/14/67 dh

09159

CERTIFICATE OF DEATH

09159

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		MARYLAND c. LENGTH OF STAY in lb <b>26yr11mth22dys</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>			d. STREET ADDRESS <b>705 E. 22nd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James</b>		First Middle Last <b>Curtain</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-03</b>		9. AGE (In years last birthday) <b>63</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drug store clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Curtain</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute, death,</b> DUE TO <b>with previous M.I. in Feb. 1955,</b> (b) <b>Arteriosclerotic Cardiovascular Mt. dis.</b> DUE TO <b>12 yrs.</b> (c) <b>Arteriosclerosis, Generalized, senile</b> <b>14 yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 18, 1967</b> to <b>July 19, 1967</b> that (we) last saw the deceased alive on <b>July 10, 1967</b> , and that death occurred at <b>2:00 PM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Anthony J. Young</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 10, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital</b> <b>Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/11/67</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Maryland</b>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUL 21 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

09158

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## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr 10mth 25dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1210 Glyndon Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Catherine</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 16, 1886</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Yugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Mchael Kovachovich</b>				14. MOTHER'S MAIDEN NAME <b>Martha Stanich</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>219-54-3090</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis, advanced</b> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>she</b> (this hospital) attended the deceased from <b>Aug. 17, 1967</b> to <b>July 18, 1967</b> , that <b>she</b> (we) lost the deceased alive on <b>July 18, 1967</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7-22/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Uniontown, Pennsylvania</b>	
24. FUNERAL DIRECTOR <i>Easton Funeral Home Catonsville</i>				25a. REC'D BY REGISTRAR DATE <b>JUL 25 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09161

CERTIFICATE OF DEATH

09161

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Ridenwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill Nursing Home</u>		d. STREET ADDRESS <u>Willow Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Cona Virginia Dempsey</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 24, 1874</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cun Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther Bosley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family information</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January 10, 1965</u> to <u>July 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1967</u> , and that death occurred at <u>1:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Post</u>		22b. DATE SIGNED <u>7/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jessop's Methodist Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10100

RECEIVED IN DECEMBER

1910

Year 1 x 100



09162

## CERTIFICATE OF DEATH

09162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Towson</u>		c. LENGTH OF STAY IN lb <u>17 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>924 S. Belwood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>DERNOGA</u> Last <u>DERNOGA</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-99</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GURSKI</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-54-6895</u>	
17. INFORMANT <u>Patients Chart Daughter, Miller</u>		Address <u>Lorraine</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerosis vascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Hypertension. Diabetic gangrene left foot</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>6-14</u> , 19 <u>67</u> , to <u>7-2</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>7-2</u> , 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. Isabelle MacGueger</u>		22b. DATE SIGNED <u>7-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE SERRA</u>		22d. ADDRESS <u>Gr. Balto. Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John J. Duda Inc. 2829 Hudson St. Balto. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

35700

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
<div style="display: flex; justify-content: space-between;"> <span>09163</span> <span>Item #2a, b, c &amp; d infor. taken from birth cert.</span> <span>09163</span> </div>															
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE COUNTY</b> <b>Greater Baltimore Medical Center</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Maryland</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>						c. LENGTH OF STAY IN 1b <b>6701 North Charles Street</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>															
3. NAME OF DECEASED (Type or print) <b>BABY GIRL</b>			First <b>BABY GIRL</b> Middle <b>DERR</b> Last <b>DERR</b>			4. DATE OF DEATH <b>7 21 19 67</b>			5. SEX <b>Female</b>						
6. COLOR OR RACE <b>Cauc.</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>7/20/67</b>			9. AGE (In years last birthday) <b>0</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>						
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>															
13. FATHER'S NAME <b>Richard E. Derr</b>						14. MOTHER'S MAIDEN NAME <b>Sharon Lee Bogema</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.			17. INFORMANT <b>from chart</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>7735</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1"> <tr> <td>(b) <b>Hyaline membrane disease</b></td> </tr> <tr> <td>(c) <b>Premature birth-low weight</b></td> </tr> </table>												(b) <b>Hyaline membrane disease</b>	(c) <b>Premature birth-low weight</b>		
(b) <b>Hyaline membrane disease</b>															
(c) <b>Premature birth-low weight</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						
20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <b>7/20, 1967</b> , to <b>7/21, 1967</b> , that (I) (we) last saw the deceased alive on <b>7/21, 1967</b> , and that death occurred at <b>6:00 p.m.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Alan M. Davick, M.D.</b>						22b. DATE SIGNED <b>7/21/67</b>			22c. PHYSICIAN'S NAME (Type) <b>Alan M. Davick, M.D.</b>						
22d. ADDRESS <b>GBMC</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>7/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greater Balto. Med. Center</b>				23d. LOCATION (City, town or county) (State) <b>Towson, Maryland</b>					
24. FUNERAL DIRECTOR <b>John E. Adams, M.D.</b>						25a. REC'D BY REGISTRAR <b>John E. Adams</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
25c. DATE <b>JUL 26 1967</b>															

02163

*A. M. L...*

*John S. Allen*

JUL 9 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

09164		09164	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY (OELLA)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY (OELLA) 03-1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2400 Westchester Ave</b>		d. STREET ADDRESS <b>2400 Westchester Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>George HENRY Dietz</b>		4. DATE OF DEATH Month <b>7</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/16</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>J. Hopkins Lab.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George Dietz - Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Askar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-10-5560</b>	
17. INFORMANT <b>Mary J. Dietz - 2400 Westchester Ave - Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture Ventricular Aneurysm</b> DUE TO (c) <b>MYOCARDIAL INFARCTION, Multiple Types</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>10 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/23</b> , 19 <b>50</b> , to <b>7/9</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>7/9/67</b> , 19 <b>—</b> , and that death occurred at <b>—</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. W. Prichard</b> M.D.		ADDRESS (Street, city or town, state) <b>7432 Furnace Br. Rd. E. 7/11/67</b>	
PHYSICIAN'S NAME (Type) <b>R. W. PRICHARD M.D. Glen Burnie, Md</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-1967</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie AA Co - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw. D. Mac Nabbs - 301 Frederick Rd - 21228</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 1967</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09165

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5118 SHELBOURNE ROAD 21227</b>				d. STREET ADDRESS <b>5118 SHELBOURNE ROAD 21227</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWIN <del>EDWARD</del> H. DORSEY</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/96</b>		9. AGE (In years lost birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry C. Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Annie Lee Francis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-12-8284</b>		17. INFORMANT <b>Mr. Norman Gaither, 5118 Shelbourne Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>974X</b> IMMEDIATE CAUSE (a) <b>Strangulation</b> DUE TO (b) <b>Hanging - self inflicted</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James N. Frederick</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <b>7/26/67</b>		
EXAMINER'S NAME (Type) <b>JAMES N. FREDERICK</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		Address (Street, city, town, or county) <b>1311 FRANCIS AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James N. Frederick</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div>3</div> <div>1</div> <div>09166</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>09166</div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>				c. LENGTH OF STAY IN 1b <b>6 Mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>				13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3120 Richwood Avenue</b>						d. STREET ADDRESS <b>3120 Richwood Avenue</b>					
3. NAME OF DECEASED (Type or print) First <b>ORIE</b> Middle <b>HARRIET</b> Last <b>DOW</b>						4. DATE OF DEATH Month <b>7</b> Day <b>1</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/25/1894</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel Bortner</b>						14. MOTHER'S MAIDEN NAME <b>Lena Bensel</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>219-10-1475</b>		17. INFORMANT Address <b>Mrs. Muriel Moore 3120 Richwood Ave.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-18-1967</b> to <b>7-1-1967</b> , that (I) (we) last saw the deceased alive on <b>6-15-1967</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Barbu Calin</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr BARBU CALIN</b>						22d. ADDRESS <b>8811 Liberty Rd. Randall City</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stansbury Funeral Home</b>						ADDRESS <b>Woodlawn, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

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CENTRIFUGAL OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09167

09167

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4107 Colonial Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD J.</u> Middle <u>DRAGON</u> Last <u></u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/47</u>	9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Dragon</u>				14. MOTHER'S MAIDEN NAME <u>Sonia Silberman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Robert Dragon-- Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AORTIC INSUFFICIENCY</u> 4211 DUE TO (b) <u>CARDIAC ENLARGEMENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>AORTIC DILATATION - AND RUPTURE</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1958</u> , 19 <u>58</u> to <u>7/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> , 19 <u>67</u> , and that death occurred at <u>7/29/67</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Alvin Stambler</u>				M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALVIN STAMBLER</u>				22d. ADDRESS <u>6941 REISTERSTOWN RD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oheb Shalom Cong.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS INC. 6010 Reist. Rd.</u>				25a. REC'D BY REGISTRAR <u>AUG 3 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ARCTIC INSURANCE

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Alvin Stamer

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09168

09168

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> c. LENGTH OF STAY IN 1b <b>30.4</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hospital</b>			d. STREET ADDRESS <b>1716 Eutaw Place</b>			
3. NAME OF DECEASED (Type or print) <b>VIRGINIA <del>XXXXX</del> DRUMGOLE (DRUMGOLD)</b>			4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan 9, 1921</b>	9. AGE (In years lost birthday) yrs. <b>46</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		
13. FATHER'S NAME <b>Albert Smith</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bettie Peace</b> Address <b>310 Jones Street</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>416X</b> IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		22. DATE SIGNED <b>July 22, 1967</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-26-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arbutus, Maryland</b>	
24. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		ADDRESS <b>1727 N. Monroe Street</b>		25a. REC'D BY REGISTRAR <b>JUL 25 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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ALBUQUERQUE, NEW MEXICO

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TO DIRECTOR

FROM ALBUQUERQUE

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09169

## CERTIFICATE OF DEATH

09169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>9 1/2 mo.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		d. STREET ADDRESS <b>426 E. Pratt Str</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN CLIFTON DUKE</b> First Middle Last		4. DATE OF DEATH Month <b>7</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12.17.1904</b>
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>W.T. DUKE</b>	
14. MOTHER'S MAIDEN NAME <b>LENA PARKER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b> <b>Peacetime 224-09-6476</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Records, Mount Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> 10021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3 years</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of lung</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10.11</b> , 19 <b>66</b> , to <b>7.25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7.25</b> , 19 <b>67</b> , and that death occurred at <b>3:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>7.25.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>7-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suffolk, Va.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 26 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Ruck</b>

1918

RECORD OF DEATH

Name of Deceased		Date of Death	
John Wilson		1918	
Age at Death		Sex	
50		Male	
Place of Birth		Cause of Death	
New York		Heart Disease	
Occupation		Married	
Farmer		No	
Education		Buried	
High School		Yes	
Religion		Buried	
Catholic		Yes	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Report		Date of Entry	
1918		1918	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09170

09170

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>			
c. LENGTH OF STAY IN 1b <b>37</b>				21222 031			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2638 LIBERTY PARKWAY</b>				d. STREET ADDRESS <b>2638 LIBERTY PKWY</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGIE JAMES DUNLAP</b>				4. DATE OF DEATH Month Day Year <b>JULY 4, 1967</b>			
5. SEX <b>MALE CAUCASIAN</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 5, 1905</b> 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FLANGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MILL</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NORMAN DUNLAP</b>				14. MOTHER'S MAIDEN NAME <b>CECEKIA BYRD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213/09/1620</b>		17. INFORMANT <b>ANNA A. DUNLAP</b> Address <b>AS IN #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>A-S-C-V-DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7-5-C-V-DISEASE</b> (c) <b>7-5-C-V-DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD - 6800</b>		22. DATE SIGNED <b>7/5/67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/7/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CATHARNA</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. CO. MD.</b>	
24. FUNERAL DIRECTOR <b>W. R. Bradley, Dundalk, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. W. Jones</b>	

05120

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15, 16.

122



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09171

CERTIFICATE OF DEATH

09171

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>TOWSON</u> <u>23-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				d. STREET ADDRESS <u>1207 Robin Hood Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl August Edberg</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-01</u> <u>65</u> yrs.	
9. AGE (In years last birthday) <u>65</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRUDENTIAL LIFE INS. CO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles A. Edberg</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>214-03-3013</u>		17. INFORMANT <u>LILLIAN A. EDBERG</u> <u>Patients Chart</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic and hypertensive cardiovascular disease</u> DUE TO (b) <u>cardiovascular disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>He</u> (this hospital) attended the deceased from <u>6-28</u> , 19 <u>67</u> , to <u>7-6</u> , 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>7/6</u> 19 <u>67</u> and that death occurred at <u>12-10AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dipak K. Mattik</u>				22b. DATE SIGNED <u>7.6.67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dipak K. Mattik</u>	
22d. ADDRESS <u>Greater Balto. Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/8/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>				25a. REC'D BY REGISTRAR <u>4905 York Rd.</u> <u>Balto. 12, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

4-17190

Baltimore

Greater Britain and Med. Centre 1205 Robinson Road

Carl

$A_{\text{avg}} + \text{avg}$

Male White

10-8-8

Baltimore Md

Charles E. Dwyer

Patent Chart

K. H. K.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09172

CERTIFICATE OF DEATH

09172

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CITY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	c. LENGTH OF STAY IN 1b <b>5 WEEKS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		d. STREET ADDRESS <b>1203 CATHEDRAL STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>GLENNA</b> Middle <b>PAULINE</b> Last <b>ELBON</b>		4. DATE OF DEATH Month <b>7</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-14</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ANALYSIS TECH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SECURITY AGENCY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>SAGO - W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GROVER CLEVELAND ELBON</b>		14. MOTHER'S MAIDEN NAME <b>SIMMONS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>236-01-8130</b>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO <b>Carcinoma Right Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/29/1967</b> to <b>7/8/1967</b> that (I) (we) last saw the deceased alive on <b>7/8/1967</b> and that death occurred at <b>11:10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Tom Poliness M.D.</b>		22b. DATE SIGNED <b>8-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>TOM POLINESS</b>		22d. ADDRESS <b>% GBMC. 6701 N. CHARLES ST. BALD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowdale</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Staley Company</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1967</b>	
ADDRESS <b>1101 E. Howard St.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2014

STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS, IN AND FOR THE COUNTY OF DALLAS

vs.

JOHN A. SMITH, Plaintiff

vs.

JANE D. SMITH, Defendant

Case No. 14-12345

Filed for Record this 14th day of May, 2014.

Attest my hand and the seal of said Court this 14th day of May, 2014.

\_\_\_\_\_  
Clerk of the District Court

\_\_\_\_\_  
John A. Smith, Plaintiff

\_\_\_\_\_  
Jane D. Smith, Defendant

\_\_\_\_\_  
Attorney for Plaintiff

\_\_\_\_\_  
Attorney for Defendant

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09173		09173									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8331 Liberty Rd</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockdale 21207</b> d. STREET ADDRESS <b>8331 Liberty Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>AGNES EMMEL</b> First Middle Last						4. DATE OF DEATH <b>7-26-1967</b> Month Day Year					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1894</b>		9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto; Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William H. Aestor</b>						14. MOTHER'S MAIDEN NAME <b>Mary Hanafin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>21163 Mrs. Matina Zopf, Old Court Rd. Woodstock, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertensive Arteriosclerotic CVD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>7-26-1967</b> to <b>7-26-1967</b> , that (I) (we) last saw the deceased alive on <b>7-26-1967</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Cesar Valle Couvero</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-26-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAUERO</b>						22d. ADDRESS <b>8629 Liberty Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>7/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION (City, town or county) (State) <b>3310 Taylor Ave; Balto; Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers, 8728 Liberty Rd; Randallstown, Md.</b>						ADDRESS <b>21133</b>		25a. REC'D BY REGISTRAR <b>JUL 31 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

02175

Bookings

1931 Cherry St

1931 Cherry St

1931 Cherry St

1931 Cherry St

1931 Cherry St

1931 Cherry St

1931 Cherry St

1931 Cherry St

1931 Cherry St



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

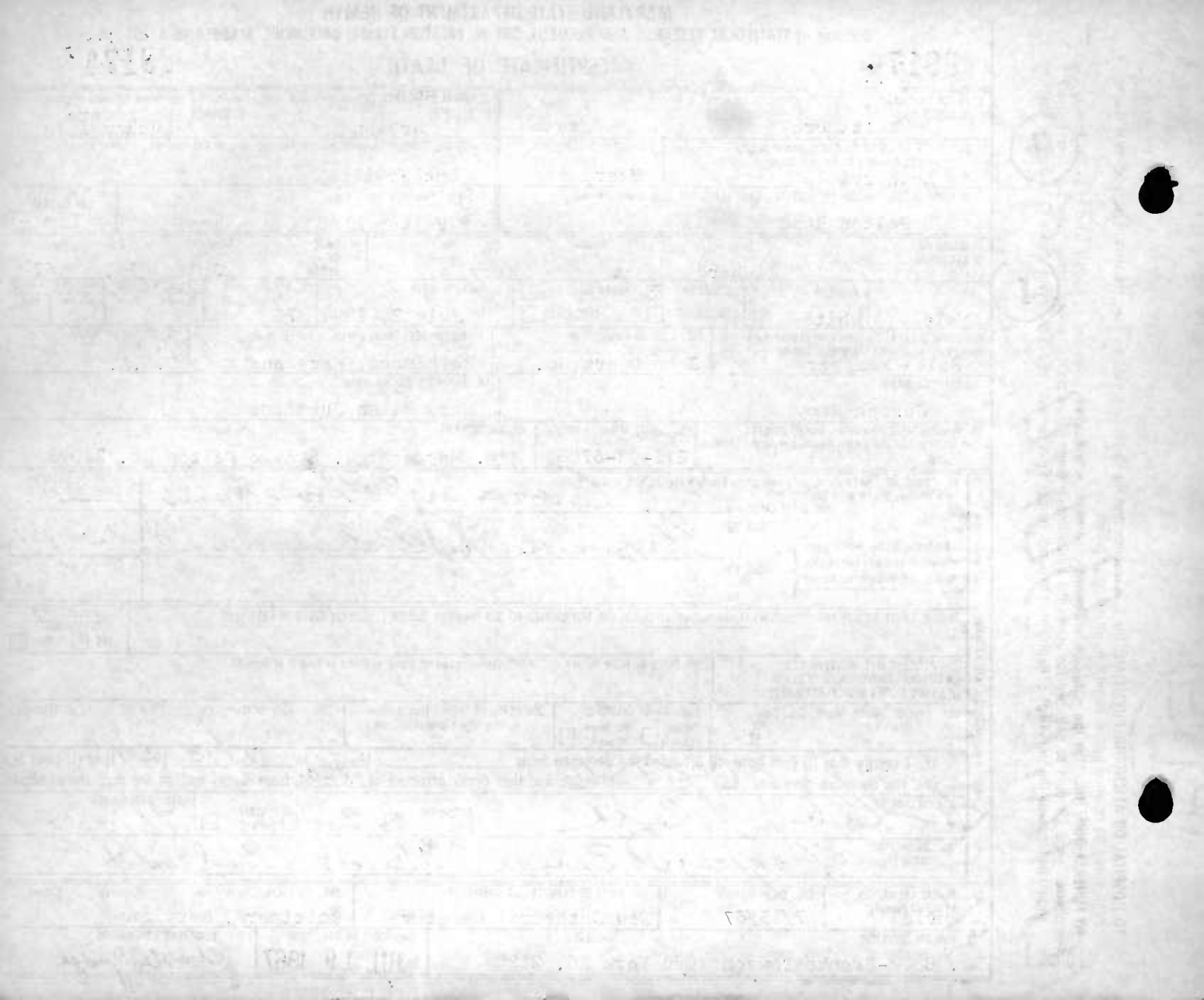
## CERTIFICATE OF DEATH

09174

09174

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> <div style="text-align: center; font-size: 1.2em;">Baltimore</div>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) o. STATE <span style="float: right;">b. COUNTY <span style="float: right;">Baltimore</span></span> <div style="text-align: center; font-size: 1.2em;">Maryland</div>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Lutherville</div>			c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.2em;">Years</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Lutherville</div>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">8 Felton Road</div>				d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">8 Felton Road</div>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <div style="text-align: center; font-size: 1.2em;">Richard A Evoy</div>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <div style="text-align: center; font-size: 1.2em;">July 13, 1967</div>					
5. SEX <div style="text-align: center; font-size: 1.2em;">Male</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">July 2, 1894</div>		9. AGE (In years last birthday) yrs. <div style="text-align: center; font-size: 1.2em;">73</div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Sales Manager</div>			10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.2em;">John Deere Co.</div>		11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">Baltimore, Maryland</div>			12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">U.S.A.</div>	
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">Joseph Evoy</div>					14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">Mary Ellen Justiana</div>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes <input checked="" type="checkbox"/> WWI			16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">213-03-6786</div>		17. INFORMANT Address <div style="text-align: center; font-size: 1.2em;">Mrs. Margaret E. Evoy 8 Felton Rd. 21093</div>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <div style="text-align: center; font-size: 1.5em;">4201</div> <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">           IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="width: 50%;">           (b) <u>Arteriosclerotic Cardiovascular Disease</u>            DUE TO            (c)         </div> </div>								INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 1.5em;">15 yrs.</div>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <span style="float: right;">19</span>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/5/66</u> to <u>7/13/67</u> , that (I) (we) lost saw the deceased alive on <u>Oct 5, 1966</u> , and that death occurred at <u>6:30 A.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <div style="text-align: center; font-size: 1.5em;">Charles J. Blazeck</div>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <div style="text-align: center; font-size: 1.5em;">7/14/67</div>			
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">CHARLES J. BLAZECK</div>				22d. ADDRESS <div style="text-align: center; font-size: 1.2em;">1116 St. Paul St.</div>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		23b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">7/15/67</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">New Cathedral Cemetery</div>		23d. LOCATION (City or Town) (County) (State) <div style="text-align: center; font-size: 1.2em;">Baltimore, Maryland</div>			
24. FUNERAL DIRECTOR ADDRESS <div style="text-align: center; font-size: 1.2em;">Wm. Cook-Brooks Towson 1050 York Rd. 21204</div>				25a. REC'D BY REGISTRAR <div style="text-align: center; font-size: 1.2em;">JUL 19 1967</div>		25b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.5em;">Charles Judge</div>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2c & d Film #G391 7/26/67 ph

09175

CERTIFICATE OF DEATH

09175

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Emma Virginia Fastie</u>		4. DATE OF DEATH <u>7 21 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Alexandria Buckmaster</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None given</u>	
17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO (b) <u>massive g.i. bleeding</u> DUE TO (c) <u>578X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6. 22.</u> , 19 <u>67</u> , to <u>7. 21.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7. 21.</u> , 19 <u>67</u> , and that death occurred at <u>11:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Sipak Kumar Malik</u>		22b. DATE SIGNED <u>7.22.67.</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Wm. Cook-Brooks Towson, 1050 York Road		25b. REGISTRAR'S SIGNATURE	
Towson, Maryland 21204		JUL 24 1967	

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH  |   |   |   |
|--|---|---|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |   |   |
| 09176  |   | CERTIFICATE OF DEATH  |   |
| 09176  |   | 09176   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> 131  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6660 Loch Hill Road</b>   |   | d. STREET ADDRESS<br><b>6660 Loch Hill Rd.</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Ethel M Fetherolf</b>  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>3</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>July 16th 1900-66</b> yrs.                           |
| 9. AGE (In years lost birthday)<br><b>66</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Medford, Wis.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |   |
| 13. FATHER'S NAME<br><b>Joseph Morrow</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Enameline McKey</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>---</b>   |   | 16. SOCIAL SECURITY NO.<br><b>214-26-7748</b>   |   |
| 17. INFORMANT<br><b>Jl-Mrs. Ethel F. Mills</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anterior sclerotic Heart Disease with atrial fibrillation</b><br>4200 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Completed</b><br>DUE TO (c) <b>Completed</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1966</b> , to <b>July 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1967</b> , and that death occurred at <b>M</b> , from causes on and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>Dr. Cesar J. Pellerano</b>  |   | 22b. DATE SIGNED<br><b>7/3/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Cesar J. Pellerano</b>  |   | 22d. ADDRESS<br><b>1311 Glenmont Road</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>7/6/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home, Inc.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 7 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles J. J.</b>  |   |   |   |

CERTIFICATE OF DEATH

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #8 & 9 Film #G391 8/3/67 ph

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 09177   |                                  | 09177  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>    |  |
| c. LENGTH OF STAY IN lb<br><b>30-4</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove Hospital</b>  |                                  | d. STREET ADDRESS<br><b>1702 Lombard Street</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>FLORINE H. FIELDS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 11, 1921</b> |
| 9. AGE (In years lost birthday)<br><b>43 42 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>12</b> Hours <b>42</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SECRET</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>ICE CREAM CO.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>LATE CARTER FIELDS</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARY E. BOARDWINE</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>HERB MOORE MIDDLEBERG VA</b>   |  |
| 17. INFORMANT<br><b>HERB MOORE MIDDLEBERG VA</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5810 IMMEDIATE CAUSE (a) Fatty infiltrate of liver</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c)   |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |  |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b>  |                                  | 22. DATE SIGNED<br><b>July 23, 1967</b>  |  |
| EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>  |                                  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>JULY 24, 1967</b>  |  |
| 23b. DATE THEREOF<br><b>JULY 24, 1967</b>   |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LEBANON</b>   |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>LEBANON, VIRGINIA</b>   |                                  | 24. FUNERAL DIRECTOR<br><b>WITKE 4101 EDMONDSON AVE BALTO, MD.</b>   |  |
| 25a. REC'D BY REGISTRAR<br><b>JUL 27 1967</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

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CERTIFICATE OF DEATH

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09178

|  |   |   |                                     |   |                                |   |  |
|--|---|---|-------------------------------------|---|--------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   |   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Baltimore City</u> |                                |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |   | c. LENGTH OF STAY IN b<br><u>2 1/2 yrs</u>  |                                     | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |                                | d. STREET ADDRESS<br><u>4431 Alan Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Stella Maris Hospice</u>  |   |   |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>John T. Fieldseth</u> JOHN T. FIELDSETH  |   |   |                                     | 4. DATE OF DEATH<br>Month Day Year<br><u>7/24/67</u> 19 <u>67</u>   |                                |   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/1/1887</u> | 9. AGE (In years last birthday)<br><u>80</u> yrs.   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Civil engineer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Engineer</u>  |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Md</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Thorwald Fieldseth</u>   |   |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Augusta Boedeker</u>   |                                |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Unknown</u>  |   | 16. SOCIAL SECURITY NO.<br><u>348-12-2251</u>   |                                     | 17. INFORMANT<br>Address<br><u>Mr. R Taylor McLean, Campbell Bldg, Towson</u>   |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)<br><u>1221 CVA</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br><u>ASCVD</u><br>DUE TO (c)                  |   |   |                                     |   |                                | INTERVAL BETWEEN ONSET AND DEATH<br><u>86 hrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |                                     |   |                                | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |   |                                |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |                                |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/24/64</u> , 19 <u>64</u> , to <u>7/24/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/23/67</u> , 19 <u>67</u> , and that death occurred at <u>7:03</u> P.M. from the causes and on the date stated above. |   |   |                                     |   |                                |   |  |
| 22a. SIGNATURE<br><u>Robert J. Mahon</u> M.D.  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |                                     | 22b. DATE SIGNED<br><u>7/24/67</u>  |                                |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Robert Mahon, M.D.</u>  |   | 22d. ADDRESS<br><u>204 E Joppa Rd, Towson</u>   |                                     |   |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 23b. DATE THEREOF<br><u>7/26/67</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cemetery</u>   |                                | 23d. LOCATION (City, town or county) (State)<br><u>Baltimore Md.</u>                              |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>  |   |   |                                     | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 27 1967</u>  |                                |   |  |
|  |   |   |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Young</u>  |                                |   |  |

09173

CERTIFICATE OF DEATH

09173

09/1987

JUL 21 1987

09179

## CERTIFICATE OF DEATH

09179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

|  |                           |   |                                       |
|--|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>                          |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>  |                           | c. LENGTH OF STAY in lb <u>21 years</u>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2707 Maple Ave</u>   |                           | d. STREET ADDRESS <u>2707 Maple Ave</u>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print) <u>Raymond R Fiorentino</u>   |                           | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>12</u> Year <u>1967</u>  |                                       |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 26 1909</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs.   |                           | 10. UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>TAILOR shops</u>   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country) <u>ITLY</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                                       |
| 13. FATHER'S NAME <u>Nicola Fiorentino</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Marie Marolla</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)  |                           | 16. SOCIAL SECURITY NO. <u>215-05-6129</u>  |                                       |
| 17. INFORMANT <u>Josephine Fiorentino</u>  |                           | Address <u>Same</u>   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Arteriosclerotic Cardio Vasc. Dis.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>with Cardiac Asthma</u><br>(c) <u>Old Myocardial Infarction</u> |                           | INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>0</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>                                     |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (1) (this hospital attended the deceased from <u>Nov</u> , 19 <u>65</u> to <u>July</u> , 19 <u>67</u> , that (1) we) last saw the deceased alive on <u>July 3</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.  |                           | 22b. DATE SIGNED <u>7/13/67</u>   |                                       |
| 22a. SIGNATURE <u>F T KASIK</u>  |                           | 22c. PHYSICIAN'S NAME (Type) <u>F T KASIK</u>   |                                       |
| 22d. ADDRESS <u>9005 Harford Rd</u>  |                           | 22e. REC'D BY REGISTRAR <u>Charles J. Jones</u>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 23b. DATE THEREOF <u>July 15 1967</u>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>  |                           | 23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MD</u>   |                                       |
| 24. FUNERAL DIRECTOR <u>C. F. EVANS</u>  |                           | 25. REC'D BY REGISTRAR <u>Charles J. Jones</u>  |                                       |
| 25a. DATE <u>JUL 14 1967</u>   |                           | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>  |                                       |

DATE OF DEATH

1917

1

with Central  
Old Imperial Bank

FT KASIK

1002  
1/13/01



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09180

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Turners Station</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>Baltimore, Maryland</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>620 Peach Orchard Lane</b>  |                                    | d. STREET ADDRESS<br><b>620 Peach Orchard Lane</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>THEODORE ROOSEVELT FLOOD</b>   |                                    | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>24</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 17, 1907</b> |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.  |                                    | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bedford County, Va.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>James Flood</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Kate Thomas</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>Nellie Palmer, 620 Peach Orchard La.</b>   |  |
| 17. INFORMANT<br><b>Nellie Palmer, 620 Peach Orchard La.</b>   |                                    | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>443X Malnutrition Dehydration</b><br>IMMEDIATE CAUSE (a) <b>ACHD</b><br>DUE TO (b)<br>DUE TO (c)   |                                    | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b> p.m.   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |  |  |
| ACTUAL SIGNATURE<br><b>Theo C Patterson</b>  |                                    | 22. DATE SIGNED<br><b>7/27/67</b>  |  |
| EXAMINER'S NAME (Type)<br><b>THEO C PATTERSON</b>  |                                    | M.D.<br><b>Charles R. Law</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 23b. DATE THEREOF<br><b>7-28-67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>  |                                    | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles R. Law 802 Madison Ave.</b>   |                                    | 25a. REC'D BY REGISTRAR<br><b>AUG 1 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles R. Law</b>  |                                    |  |  |

00120

Baltimore

Turner Station

630 Beach Orchard Lane

Male Colored

Informant

James Flood

No

June 14, 1967

Baltimore County, Va.

Kate Thomas

630 Beach Orchard Lane

Mt. Auburn

7-28-67

Brief

Charles E. Law 802 Madison Ave.

Baltimore, Maryland

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 103. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09181

|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY                           |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>   |                                  | d. STREET ADDRESS<br><b>2810 Elsinore Avenue</b>  |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mawell P. Foote</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1967</b>  |                                     |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-2-1919</b> |
| 9. AGE (In years last birthday)<br><b>48</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Taxi</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Chauffer</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>Mawell P. Foote</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Karanda M. Johnson</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>II</b>  |                                     |
| 17. INFORMANT<br><b>Sarah Foote Byrd,</b>  |                                  | Address   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>Arteriosclerotic Cardiovascular Disease</b><br>IMMEDIATE CAUSE (a) <b>4251</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO<br>(c) _____   |                                  |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |                                     |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>   |                                  | 22. DATE SIGNED<br><b>7/24/67</b>   |                                     |
| EXAMINER'S NAME (Type)   |                                  | Address (Street, city, town, or county)   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-27-67</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat.</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>Charles R. Law 802 Madison</b>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>7 25 1967</b>  |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |                                     |

00181

RECEIVED  
BALTIMORE

U.S. DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

1-2-1919

X

U.S.A.

Baltimore, Maryland

Transfer

Good

James P. Foots

James P. Foots

James P. Foots

IT

Yes

James P. Foots

*[Faint, illegible handwritten text]*

Baltimore, Maryland

Baltimore, Md.

7-27-67

Final

1-2-1919

Charles H. Lee 802 Madison

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09182

09182

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO. CO.</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sparrows Point</b>  |                               | c. LENGTH OF STAY in lb<br><b>52 yrs.</b>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>1018 "I" Street</b>   |                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARY WILLIE FOSTER</b>  |                               | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>28</b> Year <b>19 67</b>   |                                      |
| 5. SEX<br><b>F.</b>  | 6. COLOR OR RACE<br><b>N.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-14-1887</b> |
| 9. AGE (In years last birthday)<br><b>80 yrs.</b>  |                               | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Drakes Branch, Va.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>CHARLIE LEWIS</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>FANNIE LEWIS</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT<br><b>Mr. James Foster</b>   |                               | Address<br><b>1018 I Street</b>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>4200</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. } DUE TO (c) |                               |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY<br>Hour <b>e.m.</b> Month, Day, Year <b>19</b>   |                               | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>                    |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/1/65</b> , 19 <b>65</b> , to <b>7/28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/27</b> , 19 <b>67</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.                   |                               |  |                                      |
| 22a. SIGNATURE<br><b>Theo C Patterson</b>  |                               | 22b. DATE SIGNED<br><b>7/28/67</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>THEO.C PATTERSON</b>  |                               | 22d. ADDRESS<br><b>105 Main St 21222</b>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                               | 23b. DATE THEREOF<br><b>7-31-67</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>   |                               | 23d. LOCATION (City, town or county) (State)<br><b>Arbutus, Maryland</b>   |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>  |                               | 25a. REC'D BY REGISTRAR<br><b>JUL 31 1967</b>  |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>   |                               |  |                                      |

182

BRATO, CO.

BRATO, CO.

SPRINGFIELD

SPRINGFIELD

SPRINGFIELD

JOHN "I" STREET

JOHN "I" STREET

MARY

WILLIE

FOSTER

7

28

63

8-14-1937

HOUSEWIFE

HOUSE

DRINKS BENCH, VA.

U.S.A.

CHARLES LEWIS

CHARLES LEWIS

Mr. James Foster

JOHN I STREET

MORTON & DRETT F.H. 1701 LAUREL ST.

JUL 21 1937

APPROX. 1937

APPROX. 1937

APPROX. 1937



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

09183

09183

|   |                               |  |                                     |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                               | c. LENGTH OF STAY IN 1b  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3626 Oak Ave</u>  |                               | d. STREET ADDRESS <u>3626 Oak Ave</u>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>E.</u> Last <u>FRANCIS</u>  |                               | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>7</u> Year <u>1967</u>  |                                     |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>AUG 8, 1905</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER - Telephone Co</u>  |                               | 11. BIRTHPLACE (County & State, or foreign country) <u>MARION, VIRGINIA</u>  |                                     |
| 13. FATHER'S NAME <u>Everett Francis</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Cora Johnston</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes -</u>  |                               | 16. SOCIAL SECURITY NO. <u>212-10-0822</u>   |                                     |
| 17. INFORMANT <u>Tanet G. Francis - Same</u>  |                               | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>1930</u> IMMEDIATE CAUSE (a) <u>ASTROCYTOMA OF BRAIN</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MARCH, 1954</u> to <u>JULY 7, 1967</u> , that (I) <del>was</del> saw the deceased alive on <u>JULY 6, 1967</u> , and that death occurred at <u>8:15 P.M.</u> from causes and on the date stated above. |                               |  |                                     |
| 22a. SIGNATURE <u>Marvin Goldstein</u>  |                               | 22b. DATE SIGNED <u>JULY 8, 1967</u>   |                                     |
| 22c. PHYSICIAN'S NAME (Type) <u>MARVIN GOLDSTEIN</u>  |                               | 22d. ADDRESS <u>6001 PARK HEIGHTS BALTO. MD.</u>   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 23b. DATE THEREOF <u>7-11-67</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery - Baltimore, Md</u>   |                               | 23d. LOCATION (City or Town) (County) (State)  |                                     |
| 24. FUNERAL DIRECTOR <u>Ellsworth Armacost - 4600 Liberty Heights Ave</u>   |                               | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |                                     |
| DATE <u>JUL 11 1967</u>   |                               | 25b. REGISTRAR'S SIGNATURE   |                                     |

0163

STATE OF TEXAS

1917

ASTROCYTOMA OF BRAIN

JULY 2, 1917

MARCH 25

JULY 2, 1917

Marvin G. Galt

Marvin G. Galt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |   |   |   |
|---|---|---|---|
| 09184   |   | 09184   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   | c. LENGTH OF STAY in lb<br><u>7 days</u>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rt. 15 Box 58 - Baltimore, Md.</u>   |   | d. STREET ADDRESS<br><u>Rt. 15 Box 58</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>GREATER BALTIMORE MEDICAL CENTER</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Charles Earle Fresh</u>  |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>20</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Cau.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 2, 1911</u>      |
| 9. AGE (In years last birthday)<br><u>56 yrs.</u>   |   | IF UNDER 1 YEAR<br>Months <u>03</u> Days <u>1</u> Hours <u>03</u> Min. <u>1</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Foreman</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Un. Clay Bldg.</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Charles Thomas Fresh</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Heck</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.<br><u>214-05-4578</u>   |   |
| 17. INFORMANT<br><u>ETTA FRESH</u>  |   | Address<br><u>(SAME)</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>DUE TO<br>(b) <u>Pericardial effusion</u><br>DUE TO<br>(c) <u>Carcinoma of lung-treated with radiation therapy</u> |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/19, 1967</u> , to <u>7/20, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/20, 1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.                     |   |   |   |
| 22a. SIGNATURE<br><u>Rudiger Breitenecker</u>   |   | 22b. DATE SIGNED<br><u>July 21, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Rudiger Breitenecker, M.D.</u>   |   | 22d. ADDRESS<br><u>Greater Baltimore Medical Center</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR<br><u>Carl E. Charnick</u>   |   | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |   |
| ADDRESS<br><u>3617 Chestnut Ave.</u>  |   | DATE<br><u>JUL 25 1967</u>  |   |

REPORT OF THE

1906

THE COMMISSIONERS OF THE LAND OFFICE  
AND THE COMMISSIONERS OF THE DEPARTMENT OF AGRICULTURE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON JANUARY 1, 1906

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS  
1907

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS  
1907

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS  
1907

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS  
1907

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS  
1907

FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09185

|  |                                    |  |  |   |   |
|--|------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>VAN LEYAN</b>   |                                    | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>3</b> Year <b>1967</b>  |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>55</b> yrs.                                     | 9. AGE (In years lost birthday)<br><b>55</b> yrs.   | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>DISTILLERY</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>S.C.</b>  |   |
| 13. FATHER'S NAME<br><b>STATFORD GARDNER</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>YES USA</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                                    | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>AMY GARDNER 2030 E. Biddle St</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>443X</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                    |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>        |                                    |  |  |   |   |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b>   |                                    | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | 22. DATE SIGNED<br><b>July 3, 1967</b>  |   |
| EXAMINER'S NAME (Type)   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  |                                    | 23b. DATE THEREOF<br><b>7-7-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RAFT CREEK</b>                | 23d. LOCATION (City or Town) (County) (State)<br><b>SUMTER COUNTY, S.C.</b>                       |   |
| 24. FUNERAL DIRECTOR<br><b>Joseph L. Locks, Jr 1304 N. Central Ave</b>   |                                    | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 5 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                       |

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09186

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WOODLAWN</u>   |  | c. LENGTH OF STAY IN 1b<br><u>1 Mo</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>2130 Southland Rd</u>  |  | d. STREET ADDRESS<br><u>2130 Southland Rd</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Elsie MAY Gaylord</u>  |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>23</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED  | 8. DATE OF BIRTH<br><u>5-25-1880</u>                                  |
| 9. AGE (In years lost birthday) yrs.<br><u>87</u>   |  | 10. IF UNDER 24 HRS.<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>School Teacher</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Dayton, Ohio</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>ISAAC YOUNG</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>WARNER</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>274-36-0040</u>   |   |
| 17. INFORMANT<br><u>Dorothy Elliott - 2130 Southland Rd</u>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u><br>DUE TO <u>Arterio Sclerotic Arterio Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Arterio Sclerotic Arterio Vascular Disease</u><br>(c) <u>Arterio Sclerotic Arterio Vascular Disease</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u> sudden</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><u>[Signature]</u>  |  | 22. DATE SIGNED<br><u>7/24/67</u>   |   |
| EXAMINER'S NAME (Type)<br><u>[Name]</u>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>1311 Francis Ave. Balto. Md</u> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>CREMATION</u>   | 23b. DATE THEREOF<br><u>7-25-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LONDON PARK CEMETERY</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE, Md</u> |
| 24. FUNERAL DIRECTOR<br><u>Elsworth ARMOUR - 4600 Liberty Heights Ave</u>   |  | 25a. REGD BY REGISTRAR<br>DATE <u>JUL 28 1967</u>   |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |



09187

## CERTIFICATE OF DEATH

|  |                                  |   |  |  |   |   |                                |
|--|----------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u>  |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u>                    |   | b. COUNTY <u>Baltimore</u>  |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town)<br><u>Garrison</u>   |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town)<br><u>Reisterstown P.O.</u>                          |   | <u>031</u>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Foxleigh Nursing Home</u>   |                                  |   |  | d. STREET ADDRESS<br><u>Dover Road</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF DECEASED (Type or print) <u>Alan Clifford Gent</u><br>First Middle Last   |                                  |   |  |  |   |   |                                |
| 4. DATE OF DEATH <u>July 4,</u>  |                                  | Month Day Year<br><u>19 67</u>  |  |  |   |   |                                |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>October 1, 1888</u> |  | 9. AGE (In years last birthday)<br><u>78</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer-retired</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self employed</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                |
| 13. FATHER'S NAME<br><u>Orrick Gent</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Hannah Cox</u>  |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No None</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>219-36-0696</u>   |  | 17. INFORMANT Address<br><u>Family records</u>   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br>331X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>hypertension, arteriosclerosis general</u><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br>years  |                                |
| 20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)      |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>05-7-66</u> , 19 <u>   </u> , to <u>07-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-3-67</u> , 19 <u>   </u> , and that death occurred at <u>   </u> M, from causes and on the date stated above  |                                  |   |  |  |   |   |                                |
| 22a. SIGNATURE<br><u>James G. Saffell</u>  |                                  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><u>7-4-67</u>   |                                |
| 22c. PHYSICIAN'S NAME (Type)<br><u>James G. Saffell</u>  |                                  |   |  | 22d. ADDRESS<br><u>Reisterstown, Maryland</u>  |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>July 7, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Grace-Falls Rd. Cem.</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Reisterstown, Balto. Co., Md.</u>             |                                |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |                                  |   |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 10 1967</u>  |                                |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                                  |   |  |  |   |   |                                |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 09188  |  | 09188  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>Maryland</u><br>b. COUNTY <u>_____</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>3607 Loch Raven BLVD.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Gwendolyn Delia German</u><br>First Middle Last<br>4. DATE OF DEATH <u>JULY 30 1967</u><br>Month Day Year   |  | 5. SEX <u>Female</u><br>6. COLOR OR RACE <u>cau</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <u>2/23/12</u><br>9. AGE (in years last birthday) <u>55</u> yrs.<br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> |  |
| 13. FATHER'S NAME <u>Matthew Joseph white</u><br>15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>no</u><br>16. SOCIAL SECURITY NO. <u>212-18-4765</u><br>17. INFORMANT <u>FREDERICK A. GERMAN (SAME)</u><br>Address <u>(SAME)</u>   |  | 14. MOTHER'S MAIDEN NAME <u>DELIABARUEY</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>170X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Breast carcinoma with liver metastasis</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH _____   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>0500</u> p.m. <u>1967</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that (I) (this hospital) attended the deceased from <u>5/25, 1967</u> to <u>7/30, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 30 1967</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.   |  |
| 22a. SIGNATURE <u>Rahim M. Bassiri</u><br>22c. PHYSICIAN'S NAME (Type) <u>RAHIM M. BASSIRI</u>   |  | 22b. DATE SIGNED <u>7/30/67</u><br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <u>G.B.M.C. - TOWSON, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>8/2/1967</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u><br>23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>  |  | 24. FUNERAL DIRECTOR <u>Henry W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u><br>25a. REC'D BY REGISTRAR <u>AUG 1 1967</u><br>25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09189

09189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Balto.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>9 East Overlea Ave.</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Sophia</b> Middle <b>Veronica</b> Last <b>Gerst</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>1</b> Year <b>19 67</b>  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>11/8/1893</b>   |   | 9. AGE (In years last birthday) <b>73</b> yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>John F. Suhre</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sophia Deuerling</b>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Mrs Rose Hensel 266 1/2 Holly Neck Rd.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Pancreas</b><br>DUE TO (b) <b>Duodenal Obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5/6/</b> , 19 <b>67</b> , to <b>7/1/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/1/</b> , 19 <b>67</b> , and that death occurred at <b>11 p</b> M, from causes on and on the date stated above.                   |                                  |   |  |   |   |
| 22a. SIGNATURE<br><b>Jaime Ambrad</b>   |                                  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>7-1-67</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JAIME AMBRAD</b>   |                                  |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, 21204, Md.</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/5/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Josephs Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Fullerton Balto Co Md.</b>                    |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home 7401 Belair Rd.</b>   |                                  |   | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "LAW" and "OFFICE" are visible.]*

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RANDALLS TOWN</u>  |   | c. LENGTH OF STAY IN 1b<br><u>8 days</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>BALTO. CO. GEN. HOSP.</u>  |   | e. STREET ADDRESS<br><u>1362 Sudvale ROAD</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Donis</u> Middle <u>Glaser</u> Last <u>Glaser</u>   |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>4</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-23-07</u> 59 yrs.                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>MARYLAND</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Joseph Lerner</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>ETHEL Shor</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>UNKNOWN</u>   |  |
| 17. INFORMANT<br><u>Hospital Record</u>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic of CA</u><br>DUE TO <u>170X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Ca of breast</u><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-26-</u> 19 <u>67</u> , to <u>7-4-</u> 1967, that (I) (we) last saw the deceased alive on <u>7-4-</u> 1967, and that death occurred at <u>6A</u> M, from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>Dr. LAI</u>  |   | 22b. DATE SIGNED<br><u>7/4/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. LAI</u>  |   | 22d. ADDRESS<br><u>BALTIMORE COUNTY GENERAL HOSPITAL</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>7/5/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ANSHE NESTINA</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>ROSEDALE, MARYLAND</u> |
| 24. FUNERAL DIRECTOR<br><u>SOI LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>JUL 7 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>                         |

10130

MINISTRY OF HEALTH

101

AT HOME

HOSPITAL

STREET

BATIMORE COUNTY GENERAL HOSPITAL

COORRAME, MARYLAND

WASHINGT. DISTRICT

STREET

COL. LEWIS & BROS. INC. 4010 BOSTON ST. N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09191

09191

|   |                              |  |                                      |   |   |  |  |
|---|------------------------------|--|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |                              |  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> |   |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                              |  |                                      | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>                                  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>16 Howard Ave</b>  |                              |  |                                      | d. STREET ADDRESS<br><b>16 Howard Ave</b>   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Annie</b> Middle <b>L</b> Last <b>Glen</b>   |                              |  |                                      | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1967</b>   |   |  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>4/21/1871</b> |   | 9. AGE (In years last birthday)<br><b>96 yrs.</b> | IF UNDER 1 YEAR<br>Months <b>03</b> Days <b>1</b>                          | IF UNDER 24 HRS.<br>Hours <b>00</b> Min. <b>00</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                              |  |
| 13. FATHER'S NAME<br><b>unkown Diamond</b>  |                              |  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>unkown</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |                              | 16. SOCIAL SECURITY NO.<br><b>214-54-2076</b>  |                                      | 17. INFORMANT<br><b>Mr. John Glen</b>   |   | Address<br><b>16 Howard Ave - 21228</b>                                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b><br>4221 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Cardio-Vasc. Disease</b><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                              |  |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>1537</b>          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-6-1946</b> to <b>7-2-1967</b> , that (I) (we) last saw the deceased alive on <b>7-2-1967</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.  |                              |  |                                      |   |   |  |  |
| 22a. SIGNATURE<br><b>Wilmer K. Gallagher</b> M.D.   |                              |  |                                      | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |   | 22b. DATE SIGNED<br><b>7-3-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher</b>  |                              |  |                                      | 22d. ADDRESS<br><b>6209 Frederick Ave. Balt. 21228 Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>July 5, 1967</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, City Md.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Pickner &amp; Son</b>   |                              |  |                                      | ADDRESS<br><b>North &amp; Pa. Avenues</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 6 1967</b>                               |  |
|   |                              |  |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |  |  |

THE HOUSE OF DEATH

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## CERTIFICATE OF DEATH

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|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>COCKEYSVILLE</b>  |                              | c. LENGTH OF STAY IN 1b<br><b>5 1/2 YEARS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MASONIC HOME</b>  |                              | d. STREET ADDRESS<br><b>423 S. BENTLOU ST</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>IDA CATHERINE GLOSS</b>  |                              | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>4</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>FE</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/3/1889</b>                      |
| 9. AGE (In years last birthday) yrs. <b>78</b>   |                              | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>19</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>HENRY G. MAHR</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>MARY DIETZ</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                              | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>MASONIC HOME RECORDS</b>   |                              | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Compensations</b><br>DUE TO <b>AS CVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 years</b><br>DUE TO (c) |                              |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 to 7 months</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1939</b> to <b>July 1967</b> , that (I) (we) last saw the deceased alive on <b>1 July 1967</b> , and that death occurred at <b>6:30 PM</b> , from causes and on the date stated above.  |                              |   |  |
| 22a. SIGNATURE<br><b>Walter T. Kees</b>  |                              | 22b. DATE SIGNED<br><b>4 July 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>WALTER T. KEES</b>  |                              | 22d. ADDRESS<br><b>Cockeysville, Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                              | 23b. DATE THEREOF<br><b>July 7, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm Cook-Brooks Towson Md</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1967</b>   |  |
| ADDRESS<br><b>2050 York Rd Towson Md 21204</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3220

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09193

CERTIFICATE OF DEATH

09193

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>—</u>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |  | c. LENGTH OF STAY IN 1b<br><u>30-4</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Milford Manor Nursing Home</u>  |  | d. STREET ADDRESS<br><u>3626 Fords Lane, Apt 3C</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>FRANK GOLDENBERG</u>  |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>15</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>DEC. 17, 1888</u>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ENGINEER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>POWER &amp; LIGHT CO.</u>   | 9. AGE (In years last birthday)<br><u>78</u> yrs.                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTIMORE, MD.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>GABRIEL GOLDENBERG</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>LIBBY MAGGIDMAN</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>212-07-2037A</u>  |   |
| 17. INFORMANT<br><u>Mrs. Myra Roseman, 2419 Hunt Drive #9</u>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4221</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with Cerebral degeneration over 2 years</u><br>DUE TO (b) <u>1</u><br>DUE TO (c) <u>1</u>                |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Recurrent Peptic Stenosis due to Peptic Ulcer</u>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>15 July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 July</u> 19 <u>67</u> , and that death occurred at <u>3:20M</u> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><u>Lauriston L. Keown M.D.</u>   |  | 22b. DATE SIGNED<br><u>15 July 67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>DR. LAURISTON KEOWN</u>   |  | 22d. ADDRESS<br><u>431 E. LAKE AVENUE</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>7/16/67</u>  | 23b. DATE THEREOF<br><u>Burial</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Maryland Lodge</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Rosedale, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>JUL 18 1967</u>   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |   |   |                       |  |   |
|--|--|---|--|--|---|---|-----------------------|--|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |   |   |                       |  |   |
| 09194  |  |   |  |  | 09194   |   |                       |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b><br>c. LENGTH OF STAY IN 1b <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore, Md</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>21210</b><br>d. STREET ADDRESS <b>4318 Roland Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                       |  |   |
| 3. NAME OF DECEASED (Type or print) <b>JOHN B</b> First <b>GORDON</b> Middle Last  |  |   | 4. DATE OF DEATH <b>July</b> Month <b>3</b> Day <b>19</b> Year <b>67</b> |  |   |   |                       |  |   |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>6/17/1906</b>                                 |                       | 9. AGE (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. General Directory C&amp;P Telephone Co.</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Texas</b>   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b> |                       | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>Emory V. Gordon</b>   |  |   |  |  | 14. MOTHER'S MAIDEN NAME <b>Ella Hill</b>   |   |                       |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>058-05-6547</b>  |  | 17. INFORMANT <b>Mrs. Anne M. Gordon</b>   |   |   | Address <b>(Same)</b> |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>4201<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |   |   |                       |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |   |                       |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                              |                       |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/3</b> , 19 <b>67</b> , to <b>7/3</b> , 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>7/3</b> , 19 <b>67</b> , and that death occurred at <b>7:30</b> P.M. from the causes and on the date stated above.  |  |   |  |  |   |   |                       |  |   |
| 22a. SIGNATURE <b>John M. Scott</b>  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |   | 22b. DATE SIGNED <b>7/3/67</b>                                    |                       |  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>JOHN M. SCOTT</b>  |  |   |  | 22d. ADDRESS <b>600 W. BELVEDERE AVE BALTIMORE, MD 21210</b>   |   |   |                       |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>   |  | 23b. DATE THEREOF <b>7/6/1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>   |   | 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b> |                       |  |   |
| 24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>JUL 5 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                   |                       |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                          |   |  |   |                                   |  |  |                                  |
|--|--|--------------------------|---|--|---|-----------------------------------|--|--|----------------------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                          |   |  |   |                                   |  |  |                                  |
| 09195 Item 2 See Birth Certificate 09195   |  |                          |   |  |   |                                   |  |  |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                          |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>b. COUNTY<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |  |                                  |
| G.B.M.C. Baltimore, MARYLAND<br>Baltimore, Md. 21204<br>GREATER Baltimore Medical Center   |  |                          |   |  | 4107 Eierman Avenue 21206<br>Baltimore, Maryland 30.4<br>6791 N. CHARLES ST.  |                                   |  |  |                                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br>Baby Girl GORSCHBOTH  |  |                          |   |  | 4. DATE OF DEATH Month Day Year<br>July 26 1967   |                                   |  |  |                                  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>CAU. |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br>July 25, 1967 |  | 9. AGE (In years last birthday) yrs. Months Days Hours Min.<br>19 38 |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>N/A   |  |                          | 10b. KIND OF BUSINESS OR INDUSTRY<br>N/A  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Baltimore, Maryland  |                                   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |                                  |
| 13. FATHER'S NAME<br>Robert Carroll GORSCHBOTH   |  |                          |   |  | 14. MOTHER'S MAIDEN NAME<br>Lorraine Alberta Alexander  |                                   |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>N/A   |  |                          | 16. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT<br>—  |                                   |  | Address  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7735 Respiratory Distress Syndrome<br>DUE TO (b) Prematurity and low birth weight<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                          |   |  |   |                                   |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                          |   |  |   |                                   |  |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                          |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |                                   |  |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19   |  |                          | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)                             |  |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from 7/25, 1967, to 7/26, 1967, that (I) (we) saw the deceased alive on 7/26, 1967, and that death occurred at 2:00 PM, from the causes and on the date stated above.   |  |                          |   |  |   |                                   |  |  |                                  |
| 22a. SIGNATURE<br>Alan M. Savick   |  |                          |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                                   |  | 22b. DATE SIGNED<br>7/26/67  |                                  |
| 22c. PHYSICIAN'S NAME (Type)   |  |                          |   |  | 22d. ADDRESS  |                                   |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>cremation   |  |                          | 23b. DATE THEREOF<br>7/29/67  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GAMC  |                                   | 23d. LOCATION (City, town or county) (State)<br>Towson Md. 21204 |  |                                  |
| 24. FUNERAL DIRECTOR<br>John E. Adams, M.D. Gamc   |  |                          |   |  | 25a. REC'D BY REGISTRAR<br>DATE JUL 31 1967   |                                   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                      |  |                                  |

7-254357

1/2/67 G.M.C.  
 P. in 5. Adams, W.D. G.M.C.

Towson, Md. 21204

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]

Robert Garret Gershbort Lorraine Alberta Alexander  
 N/A N/A

Female Can. July 25, 1951

Baby Girl Gershbort July 25

Greater Baltimore Medical Center 600 N. Charles St.

Baltimore, Md. 21204

G.M.C. Baltimore

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VR A15 (4)  
25M 1/67

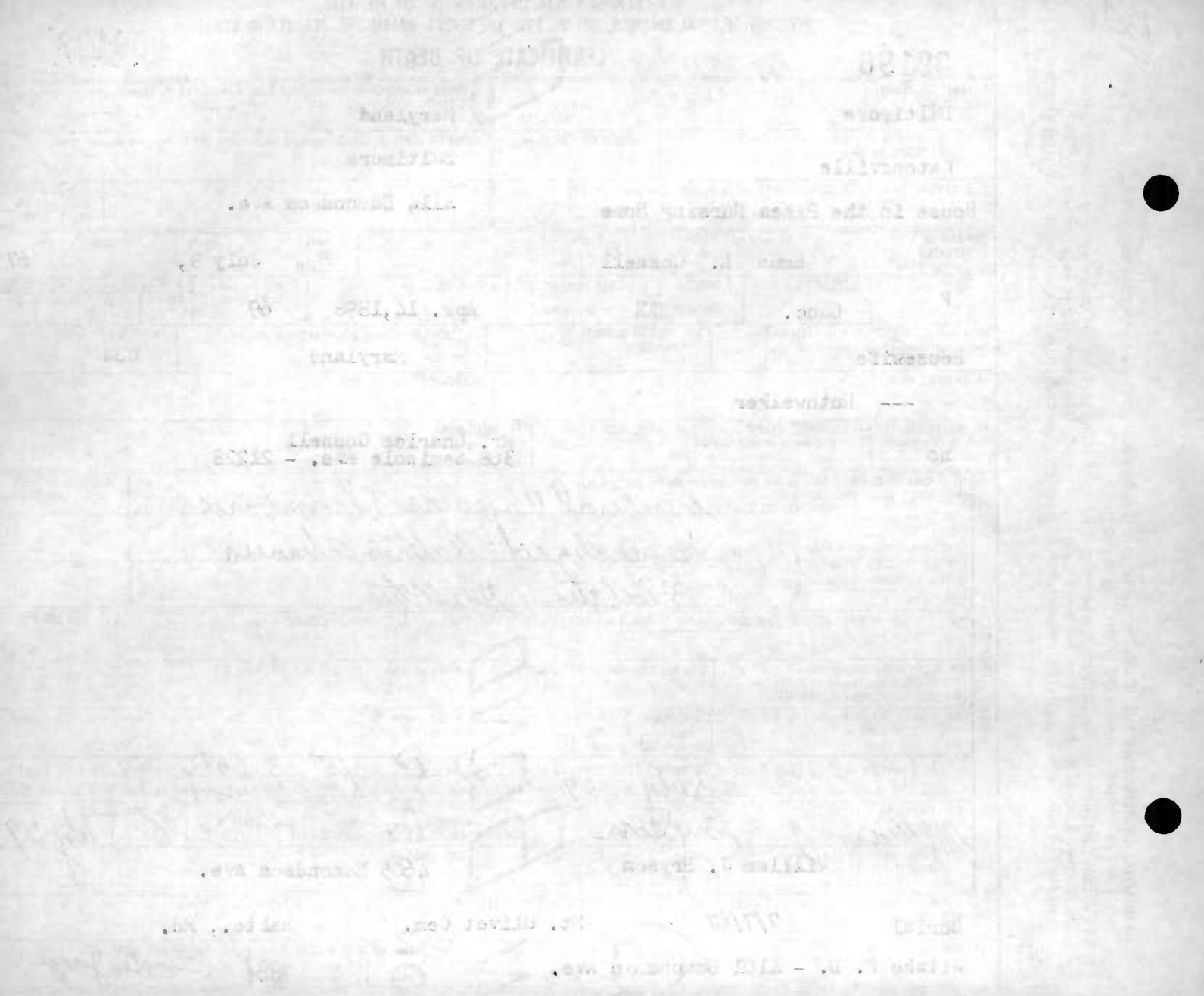
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09196

09196

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN It<br><b>20-4</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>House in the Pines Nursing Home</b>   |  | d. STREET ADDRESS<br><b>4114 Edmondson Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Emma L. Gosnell</b><br>First Middle Last   |  | 4. DATE OF DEATH<br><b>July 3, 1967</b><br>Month Day Year   |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>Cauc.</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 14, 1898</b><br>9. AGE (In years lost birthday) yrs. <b>69</b>        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>--- Huthwelker</b>   |  | 14. MOTHER'S MAIDEN NAME  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mr. Charles Gosnell</b><br><b>308 Seminole Ave. - 21228</b><br>Address   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Thrombosis</b><br>DUE TO<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) <b>Diabetes mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. 19<br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>3 July 1967</b> , that (I) (we) last saw the deceased alive on <b>3 July 1967</b> , and that death occurred at <b>8:00 P.M.</b> from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>William J. Bryson</b>   |  | 22b. DATE SIGNED<br><b>5 July 67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>William J. Bryson</b>   |  | 22d. ADDRESS<br><b>4605 Edmondson Ave.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/7/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bal to., Md.</b>                              |
| 24. FUNERAL DIRECTOR<br><b>Witzke F. D. - 4101 Edmondson Ave.</b><br>ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 7 1967</b>   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                               |  |  |
|---|-------------------------------|--|--|
| 09197   |                               | 09197  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown P.O.</i>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>   |  |
| c. LENGTH OF STAY IN 1b <i>76 years</i>   |                               | d. STREET ADDRESS <i>Falls Rd</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Falls Rd</i>  |                               | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Robert</i> Middle <i>Griffith</i> Last <i>Griffith</i>  |                               | 4. DATE OF DEATH<br>Month <i>July</i> Day <i>3</i> Year <i>1967</i>  |  |
| 5. SEX <i>Female</i>  | 6. COLOR OF RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>26 January 1891</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewifery</i>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <i>Harrisburg, Penna</i>  |                               | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  |
| 13. FATHER'S NAME <i>William David Griffith</i>   |                               | 14. MOTHER'S MAIDEN NAME <i>Emma Given</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) <i>None</i>   |                               | 16. SOCIAL SECURITY NO. <i>215-42-7979</i>   |  |
| 17. INFORMANT <i>Sister - Margaret Griffith</i>   |                               | Address <i>- Same</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i><br>4221<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vascular Disease</i><br>DUE TO (c) <i>20 years over</i> |                               | INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1976</i> to <i>July</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>20 June</i> 19 <i>67</i> , and that death occurred <i>6:20</i> P.M. from the causes and on the date stated above.   |                               |  |  |
| 22a. SIGNATURE <i>Walter T. Kees</i>  |                               | 22b. DATE SIGNED <i>3 July 67</i>  |  |
| 22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>  |                               | 22d. ADDRESS <i>Cockeysville, Md</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                               | 23b. DATE THEREOF <i>July 6, 1967</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Old Gunpowder Meeting House</i>   |                               | 23d. LOCATION (City, town or county) (State) <i>Cockeysville, Md</i>   |  |
| 24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>  |                               | 25a. REC'D BY REGISTRAR <i>JUL 10 1967</i> 25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>  |  |





CERTIFICATE OF DEATH

09198

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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|  |                                  |   |   |  |  |   |   |
|--|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Cockeysville</b> 21030 |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cockeysville 21030</b>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>Greensway &amp; Falls Road</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>George Earl Guetler</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>22</b> Year <b>1967</b>   |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>September 19, 1918</b> |  | 9. AGE (In years last birthday) <b>48</b> yrs. |   | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bowling Lane Mechanic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fairlanes, Inc.</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   |
| 13. FATHER'S NAME<br><b>George P. Guetler</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Oldham</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>WW 11</b>   |   | 17. INFORMANT<br><b>Family records</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>465X</b> IMMEDIATE CAUSE (a) <b>Pulmonary thrombo-embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____<br>DUE TO (c) _____ |                                  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Carcinomatosis, primary in lung</b>   |                                  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o.m.</b> <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>ot work ot work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>July 13,</b> 1967, to <b>July 22,</b> 1967, that <b>we</b> (we) last saw the deceased alive on <b>July 22,</b> 1967, and that death occurred at <b>7:45</b> M, from causes and on the date stated above.  |                                  |   |   |  |  |   |   |
| 22a. SIGNATURE<br><b>Reynaldo Orjuela-Gomez, M. D.</b>   |                                  |   |   | 22b. DATE SIGNED<br><b>July 22, 1967</b>   |  | 22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M. D.</b>                                 |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  |   |   | 23b. DATE THEREOF<br><b>July 25, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                                 |   |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 26 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |   |

THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO

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CERTIFICATE OF DEATH

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|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Monkton</b><br>c. LENGTH OF STAY IN 1b<br><b>87</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Monkton, Md.</b><br>d. STREET ADDRESS<br><b>13-1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Grace Slade Guthrie</b><br>First Middle Last   |   | 4. DATE OF DEATH<br><b>July 24, 1967</b><br>Month Day Year  |  |
| 5. SEX<br><b>F.</b>   | 6. COLOR OR RACE<br><b>White</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Aug. 25, 1879</b><br>Month Day Year                 |
| 9. AGE (In years and months)<br><b>87</b><br>Yrs. Mos.  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Monkton, Md.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 13. FATHER'S NAME<br><b>Alexander Guthrie</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Catherine Lanus</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) (If yes give war or dates of service)<br><b>No</b>  |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Florence Guthrie, Monkton, Md. 21111</b><br>Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Arterio sclerosis Cordis Vasculis Disease</b><br>DUE TO<br>(c) <b>3 yr</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)  |   | 21. I certify that (I) (this hospital) attended the deceased from <b>5-15</b> , 19 <b>67</b> , to <b>7-24</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>7-23</b> , 19 <b>67</b> , and that death occurred at <b>12:30</b> A.M., from causes and on the date stated above.  |  |
| 22a. SIGNATURE<br><b>C. Herbert Mueller Jr</b><br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22b. DATE SIGNED<br><b>7-25-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. HERBERT MUELLER JR</b>  |   | 22d. ADDRESS<br><b>PARKTON, Md. 21126</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>July 26, 67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Clynmalira</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b><br>ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 31 1967</b><br>OATE   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |  |

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Active release Co  
Covered folder

*Artibeus schlegelii* (Cuvier) (Mammalia)

Charles M. Miller

2. ROBERT WILSON PARKIN, JR., 3125

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## CERTIFICATE OF DEATH

09200

09200

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|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>29.1</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b> |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Balto.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21234</b><br>d. STREET ADDRESS<br><b>9535 Powderhorn Lane</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>George</b><br>First Middle Last<br><b>HAASE</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 27, 19 67</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>September 22, 1903</b><br>9. AGE (In years last birthday)<br><b>63</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Kelly</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                             |
| 13. FATHER'S NAME   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Gene Croucher</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>  |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br><b>Helin Haase</b> Address <b>9535 Powderhorn</b>                                 |

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|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>451X</b> IMMEDIATE CAUSE (a) <b>Ruptured abdominal aneurysm</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town) (County) (State)  |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 27, 19 67</b> , to <b>July 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 27, 19 67</b> , and that death occurred at <b>11:30M</b> , from causes and on the date stated above.   |  |   |
| 22a. SIGNATURE<br><b>Frank A. Faraino</b>   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED<br><b>July 27, 1967</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frank A. Faraino, M.D.</b>   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL, SPECIFY  | 23b. DATE THEREOF<br><b>7/30/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calwood</b>  |
| 23d. LOCATION (City or town) (County) (State)<br><b>Balto</b>   |  |   |
| 24. FUNERAL DIRECTOR<br><b>Pa. Delemaun</b>   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 1 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09201

|  |                                  |   |                                    |  |  |   |   |
|--|----------------------------------|---|------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Alleg.</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills, Md.</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>14 yrs</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>                               |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>   |                                  |   |                                    | d. STREET ADDRESS<br><b>20 Main St.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br><b>James Peter Habeeb</b>   |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>6</b> Year <b>1967</b>  |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-12-29</b> |  | 9. AGE (In years birthday) yrs.<br><b>37</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Keyser, W. Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph F. Habeeb</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Nettie Slailey</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                    | 17. INFORMANT Address<br><b>Rosewood St. Hosp. Records</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>3255</b> IMMEDIATE CAUSE (a) <b>Asphyxia due to bolus of food in larynx</b><br>DUE TO (b) <b>Mental Deficiency</b><br>DUE TO (c) <b>Spastic quadriplegia- Chr. Osteomyelitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                                  |   |                                    |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Spastic quadriplegia- Chr. Osteomyelitis</b>  |                                  |   |                                    |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>   |                                    |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>5:50</b> Hour <b>7-6-67</b> 19<br>p.m.  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><b>Rosewood St. Hosp</b>                                    |  | 20f. (City or town) (County) (State)<br><b>Owings Mills Balto Md.</b>                             |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                    |  |  |   |   |
| ACTUAL SIGNATURE<br><b>D. D. Caples</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                    |  |  |   |   |
| EXAMINER'S NAME (Type)<br><b>D. D. Caples, M. D.</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                    |  |  |   |   |
|  |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                    |  |  |   |   |
|  |                                  | Address (Street, City, town, or county)<br><b>6 Hanover Rd. Reisterstown, Md.</b>   |                                    |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>July 10, 67</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosewood Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Owings Mills, Md.</b>                         |   |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons</b>  |                                  |   |                                    | ADDRESS<br><b>Reisterstown, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1967</b>   |   |
|  |                                  |   |                                    |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |  |  |   |   |  |  |
|--|--|----------------------------------|---|---|--|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |  |   |   |  |  |
| CERTIFICATE OF DEATH   |  |                                  |   |   |  |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> |  |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>  |  |                                  |   | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>near Towson, Maryland</b> |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOME: 1001 Arran Road</b>   |  |                                  |   |   | d. STREET ADDRESS<br><b>1001 Arran Road</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  |                                  | First <b>ROBERT</b>   |   | Middle <b>HAROLD</b>   |  | Last <b>HABERCAM</b>  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1967</b> |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1906</b><br><b>Dec. 31, 1906</b>   |   | 9. AGE (In years last birthday) <b>60</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min.          |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired bookkeeper</b>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>                                |   | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 13. FATHER'S NAME<br><b>Frank M. Habercam</b>  |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Rose Cunningham</b>   |  |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-01-9663</b>   |   | 17. INFORMANT: <b>wife</b>   |  |   | Address <b>Md. 21212</b>  |  |  |
|  |  |                                  |   |   | <b>Betty Mae Habercam, 1001 Arran Rd., Balto Co</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent myocardial infarction</b><br>4201<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary arteriosclerosis</b><br>(c) <b>Diabetes Mellitus</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Second</b><br><b>72 yrs.</b>                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                    |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 22, 1949</b> , to <b>July 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 25 1967</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.   |  |                                  |   |   |  |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Frederick J. Vollmer</b>  |  |                                  |   |   | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><b>July 24 1967</b>                                 |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>FREDERICK J VOLLMER</b>   |  |                                  |   |   | 22d. ADDRESS<br><b>6100 York Rd Balto. Md 21212</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>7/26/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Balto. City, Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Stewart &amp; Mowen Co., 108 W. North Av., City</b>   |  |                                  |   |   | ADDRESS<br><b>21201</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 26 1967</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Jones</b>                  |  |

30303

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS

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09203

## CERTIFICATE OF DEATH

09203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE CO</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWSON Aged</u>  |   | c. LENGTH OF STAY IN lb<br><u>6 yrs 5 mo</u>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE</u>  |   | 304   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>AGED WOMENS &amp; AGED MENS HOME</u>   |   | d. STREET ADDRESS<br><u>629 DUMBARTON AVE.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edna</u> Middle <u>E.</u> Last <u>HAILE</u>   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>17</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-22-1886</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>R. Nurse</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><u>80</u> yrs.   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTIMORE MD</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>Thomas J. HAILE</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth J. SLADE</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |   | 16. SOCIAL SECURITY NO.<br><u>218-18-1142</u>   |   |
| 17. INFORMANT<br><u>Horis Sherman</u>   |   | Address <u>Towson md 615 Chestnut ave</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCVD</u><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u><br><u>4 yrs</u>                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>C-U-A 4 yrs ago</u>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>February 14, 1961</u> , to <u>July 17, 1967</u> , that (I) (we) lost saw the deceased alive on <u>July 17, 1967</u> , and that death occurred at <u>6 P.M.</u> from causes and on the date stated above.                                       |   |   |   |
| 22a. SIGNATURE<br><u>Newland E. Day</u>   |   | 22b. DATE SIGNED<br><u>July 18, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Newland E. DAY</u>   |   | 22d. ADDRESS<br><u>4-E-33rd ST Balto. Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>July 20, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Chestnut Grove</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Balt. Co. Md.</u>                             |
| 24. FUNERAL DIRECTOR<br><u>Wm. Code. Brooks Towson</u>  |   | 25a. REC'D BY REGISTRAR<br><u>20 JUL 20 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |   |   |

# STATE OF TEXAS

30500

1901 JUN 10



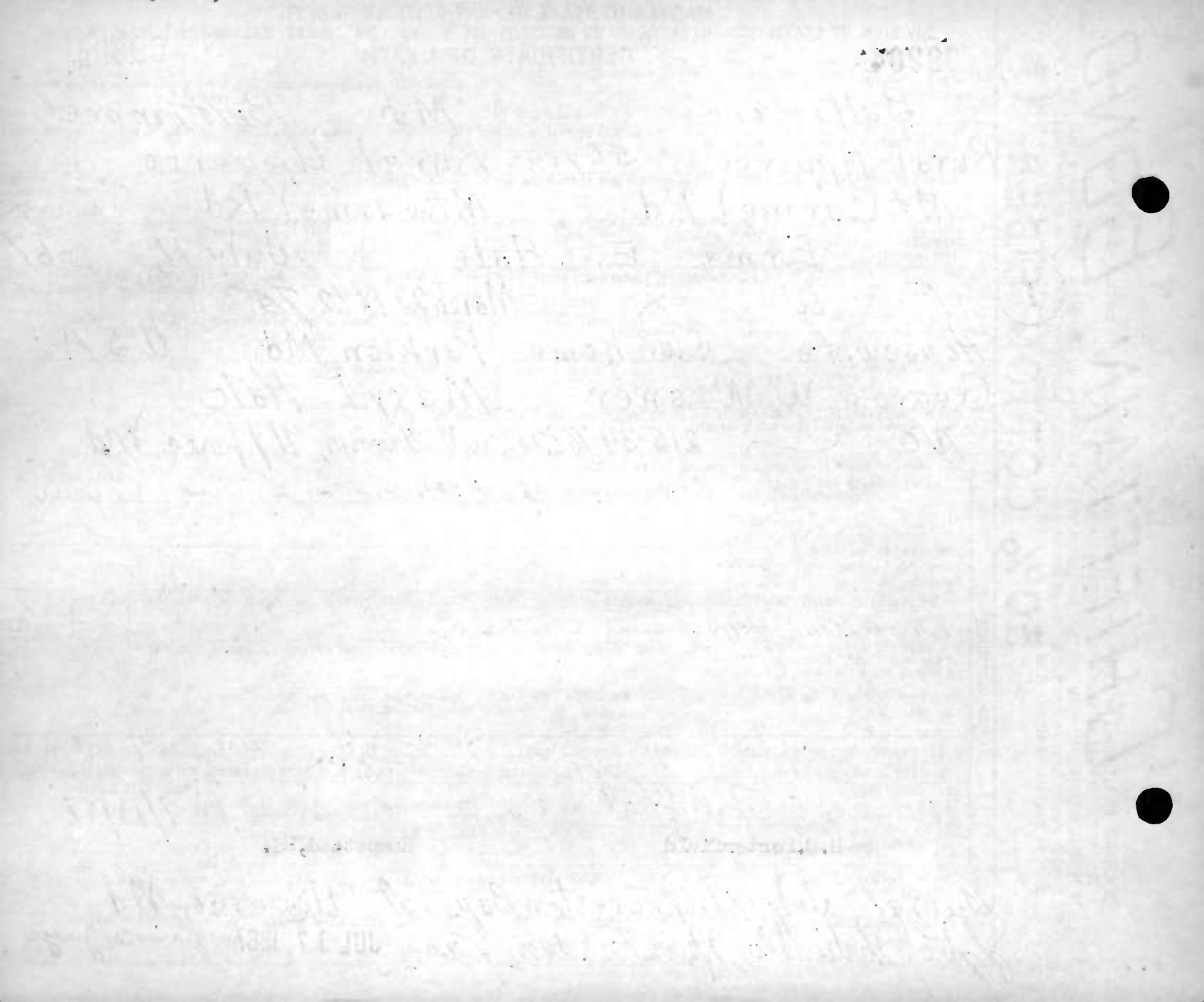
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |   |   |  |   |  |
|--|--|---|---|---|---|---|--|---|--|
| CERTIFICATE OF DEATH   |  |   |   |   |   |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Rural-Upperco</u>   |  |   | c. LENGTH OF STAY IN 1b<br><u>50 yrs.</u> |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Rural-Upperco</u>                                |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Mt. Carmel Rd.</u>  |  |   |   |   | d. STREET ADDRESS<br><u>Mt. Carmel Rd.</u>  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Erma E. Hale</u>  |  | First Middle Last   |   | 4. DATE OF DEATH<br><u>July 11</u> 19 <u>67</u>   |   | Month Day Year  |  |   |  |
| 5. SEX<br><u>F</u>   |  | 6. COLOR OR RACE<br><u>W</u>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>March 22 1892</u>                            |  | 9. AGE (In years last birthday)<br><u>75</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Parkton, Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                       |  |   |  |
| 13. FATHER'S NAME<br><u>George W. Wisner</u>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Hale</u>   |   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  |   |   | 16. SOCIAL SECURITY NO.<br><u>215-34-7082</u>   |   | 17. INFORMANT<br><u>Doris V. Grumm, Upperco, Md.</u>                |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of H. Bladder &amp; Liver</u><br><u>1551</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |  |   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes; Hypertensive C-v. Disease</u>  |  |   |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>7-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> , 19 <u>67</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.  |  |   |   |   |   |   |  |   |  |
| 22a. SIGNATURE<br><u>Manner C. Porterfield</u>   |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22b. DATE SIGNED<br><u>7/13/67</u>                                  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>   |  |   |   | 22d. ADDRESS<br><u>Hampstead, Md.</u>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF<br><u>July 14 1967</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Foreston Baptist</u>   |   | 23d. LOCATION (City, town or county) (State)<br><u>Upperco, Md.</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Robert Hartenstein, New Freedom, Pa.</u>  |  |   |   | 25a. REC'D BY REGISTRAR<br><u>JUL 17 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                  |  |   |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Item #4 Film #G391 8/2/67 ph Items 8 & 9 Film G 392 8/29/67 jml  
09205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09205

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>BALTO</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO Rural Overlea</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO Rural Overlea</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11 West Elm</b>  |  | d. STREET ADDRESS <b>11 West Elm</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>MILDRED ELLEN HALL</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>24</b> Year <b>19 67</b>  |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 8. DATE OF BIRTH <b>4-25-23</b> 9. AGE (In years) <b>44</b> last birth <b>46</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |  |
| 13. FATHER'S NAME <b>John P. Mc Donough</b>  |  | 14. MOTHER'S MARDEN NAME   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>none</b>  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Family records</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot (12 gauge)</b><br>DUE TO (b) <b>976X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>DUE TO (c)  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Depression</b>   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted shotgun blast thru mouth</b>                                      |  |
| 20c. TIME OF INJURY Month, Day, Year <b>2:30 p.m. 7-24 19 67</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>   | 20f. (City or town) <b>BALTO - OVERLEA MD</b> (County) (State)                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <b>John C. Ayle</b> M.D.  |  | 22. DATE SIGNED <b>7-24-67</b>   |  |
| EXAMINER'S NAME (Type) <b>JOHN C. Ayle</b>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Assistant Medical Examiner <input type="checkbox"/><br>Address (Street, city, town, or county) <b>7527 Belair Rd</b> |  |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>7/28/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Satys Cemetery</b>   | 23d. LOCATION (City or Town) <b>Lutherville Md.</b> (County) (State)             |
| 24. FUNERAL DIRECTOR <b>John Burns Sons</b>  |  | 25a. REC'D BY REGISTRAR <b>Towson Md.</b> DATE <b>JUL 31 1967</b>  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

2082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09206

CERTIFICATE OF DEATH

09206

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>  |  |
| c. LENGTH OF STAY IN 1b <u>30 days</u>  |   | d. STREET ADDRESS <u>Hillcrest Ave.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. med Center</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Harry Smokey Hammond</u>   |   | 4. DATE OF DEATH <u>7</u> Month <u>9</u> Day <u>19</u> Year <u>67</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Cauc</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-16-1886</u>   |
| 9. AGE (In years last birthday) <u>80</u> yrs.  |   | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Clinton Hammond</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Ida S Herill</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>219-36-0922</u>   |  |
| 17. INFORMANT <u>PT's chart</u>   |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).<br><u>Benign prostatic hypertrophy - urinary retention - ? Ca prostate.</u>   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 1B.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/9</u> , 19 <u>67</u> , to <u>7/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> , 19 <u>67</u> , and that death occurred at <u>7:00 P.M.</u> from causes and on the date stated above.   |   |  |  |
| 22a. SIGNATURE <u>Derek A Bruce</u>   |   | 22b. DATE SIGNED <u>7/9/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>  |   | 22d. ADDRESS <u>G. B. M.C.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF <u>July 12, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Gdns</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Timonium Balto. Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Sacob Hartenstein</u>   |   | 25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>   |  |
| ADDRESS <u>New Freedom, Pa.</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |

30300

DEPARTMENT OF DEATH

30300

Order recorder accident

Order recorder accident

Order recorder accident

DEREK A BRUCE

DEREK A BRUCE

G. B. H. C.



09207

## CERTIFICATE OF DEATH

09207

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  | c. LENGTH OF STAY IN 1b<br><u>13 days</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Greater Balt. Med. Center</u>  |  | d. STREET ADDRESS<br><u>2100 Lukewood Dr.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Philip Gus Harman</u>   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>21</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Cauc.</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>01 10-17-02</u>        |
| 9. AGE (In years lost birthday)<br><u>65</u> yrs.   |  | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/><br>Months Days Hours Min.   |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>unknown - Doctor</u>  |  | 11b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ellicott City Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>James Harman</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>unknown</u>  |  | 16. SOCIAL SECURITY NO.<br><u>218-14-5598</u>   |   |
| 17. INFORMANT<br><u>Sney B Needle - 343 N Calvert St</u>  |  | <u>Patients Chart</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>420.1<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Arteriosclerotic Heart disease</u><br>DUE TO<br>(c) <u>Rheumatic heart disease &amp; Mitral Regurgitation</u> |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 7</u> , 19 <u>67</u> , to <u>July 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 21</u> , 19 <u>67</u> , and that death occurred at <u>1:40 AM</u> , from causes and on the date stated above   |  |   |   |
| 22a. SIGNATURE<br><u>[Signature]</u> M.D.   |  | 22b. DATE SIGNED<br><u>7-21-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)  |  | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State) |
| <u>BURIAL</u>   | <u>7-25-67</u>   | <u>Lakeview Memorial Cemetery</u>   | <u>Balto. Md.</u>                             |
| 24. FUNERAL DIRECTOR<br><u>Elsworth Armacost - 4600 Liberty Heights Ave</u>   |  | 25a. REGD BY REGISTRAR<br><u>JUL 25 1967</u>  |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2025

RECEIVED

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09208

## CERTIFICATE OF DEATH

09208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL CATONSVILLE</u>   |  | c. LENGTH OF STAY IN 1b<br><u>8 YRS</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SUMMIT NURSING HOME</u><br><u>FREDERICK AVE</u>   |  | d. STREET ADDRESS<br><u>6215 JOHNNYCAKE RD.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>JOE</u> Middle <u>HENRY</u> Last <u>HARRELL</u>   |  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>11</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4/20/81</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CARPENTER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>PET.</u>  | 9. AGE (In years last birthday)<br><u>86</u> yrs.   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>ROCKINGHAM County, N.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>HENRY HARRELL</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>ELLA BAYNES</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>239-18-5872A</u>  |   |
| 17. INFORMANT<br><u>J. W. HARRELL</u>  |  | Address <u>ELLICOTT CITY, MD</u><br><u>42 DEERFIELD DRIVE</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION &amp; ASPHYXIA</u><br>DUE TO (b) <u>INANITION &amp; RT. HEMIPARESIS</u><br>DUE TO (c) <u>CEREBRAL THROMBOSIS</u>          |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>26 days</u><br><u>26 days</u>                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>15 JUNE, 1967</u> , to <u>11 JUL, 1967</u> , that (I) (we) last saw the deceased alive on <u>6 JUL 1967</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><u>Irwin H. Moss, MD</u>   |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>IRWIN H. MOSS, MD</u>  |  | 22d. ADDRESS<br><u>5836 WESTVIEW MALL, BALTO, MD 21228</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>7/14/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>GUILDFORD MEM.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>GREENSBORO, N.C.</u>                          |
| 24. FUNERAL DIRECTOR<br><u>E.S. MACNABB</u>  |  | 25a. REC'D BY REGISTRAR<br><u>301 FREDERICK RD</u><br><u>21228</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>HANES LINEBURE F.H.</u>   |  | DATE <u>JUL 13 1967</u>   |   |

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FILE

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09209

09209

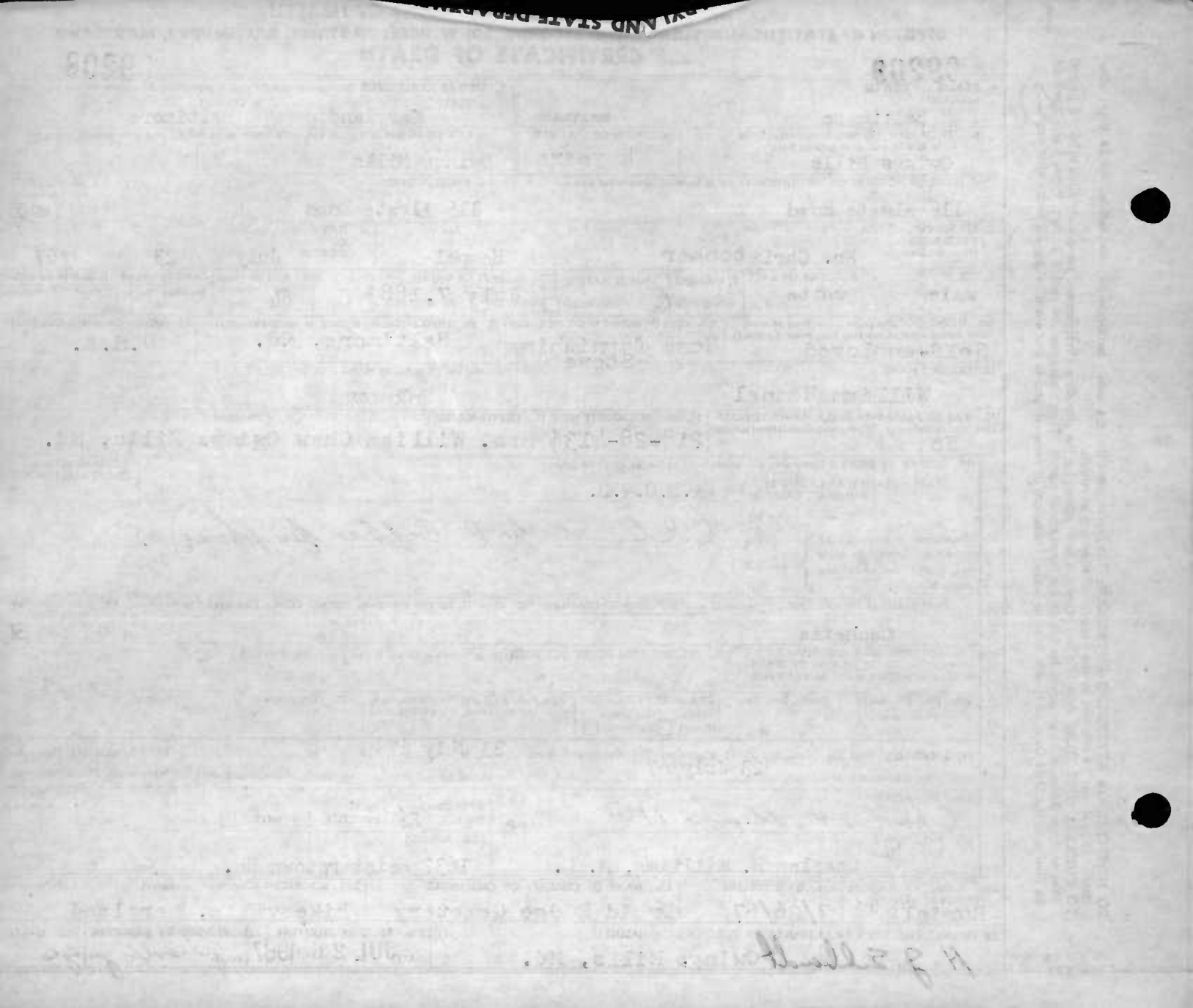
|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |  |   |  | c. LENGTH OF STAY IN TB<br><b>4 years</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>115 Algate Road</b>   |  |   |  | d. STREET ADDRESS<br><b>115 Algate Road</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Mr. Christopher Hempel</b>   |  |   |  | 4. DATE OF DEATH<br><b>July 23 1967</b>  |  |  |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 7, 1883</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days  |  | 11. IF UNDER 24 HRS.<br>Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self-employed</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home furnishing Store</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>William Hempel</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>218-28-4136</b>  |  |  |  |
| 17. INFORMANT<br><b>Mrs. William Chew Owings Mills, Md.</b>  |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b><br><b>H221</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>(Released by Dr. Caples per phone.)</b><br>(c) <b>(Released by Dr. Caples per phone.)</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Cachexia</b> |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>23 July 67</b> , 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Charles H. Williams, M.D.</b>   |  |   |  | 22b. DATE SIGNED   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Charles H. Williams, M. D.</b>            |  |
| 22d. ADDRESS<br><b>1632 Reisterstown Rd.</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/26/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Pikesville, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. J. Schmitt</b>   |  |   |  | ADDRESS<br><b>Owings Mills, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 26 1967</b>                                |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

H. J. Webb

July 2, 1906





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>  | c. LENGTH OF STAY in lb <b>26 days</b>                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTO. Co. General</b>   |   | d. STREET ADDRESS <b>3414 Mayfair Rd.</b>  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <b>CARRIE A. HERBOLD</b>   | 4. DATE OF DEATH <b>7</b> Month <b>4</b> Day <b>19</b> Year <b>67</b> |  |  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2-8-'80</b>  |
| 9. AGE (In years last birthday) <b>87</b> yrs.   |   | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  | 11. BIRTHPLACE (State or foreign country) <b>Balto.</b>  |
| 12. CITIZEN OF WHAT COUNTRY? <b>W.S.A.</b>   |   |  |  |
| 13. FATHER'S NAME <b>CONRAD SCHUMANN</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Mary SCHMIDT</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>  |   | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Wm. Edw. Herbold (Same)</b>   |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>4201 DUE TO<br>(b) <b>Probable Myocardial Infarction</b><br>DUE TO<br>(c) <b>or Acute Cardiac Arrhythmia</b>  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Fractured L. hip June 8, 1967 nailed 2-11-'67</b>   |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Patient fell at home</b>                              |  |
| 20c. TIME OF INJURY Hour <b>2</b> p.m. Month, Day, Year <b>6-8 1967</b>  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>             |
| 20f. (City or town) <b>Balto.</b> (County) (State) <b>Md.</b>  |   |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE <b>D.D. Caples</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <b>D.D. CAPLES, M.D.</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
|  |   | Address (Street, city, town, or county)  |  |
| 22. DATE SIGNED <b>7-5-'67</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>7-7-67</b>                                       | 23c. NAME OF CEMETERY OR CREMATORY <b>London Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Md.</b>                            |
| 24. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hgts.</b>  |   | 25a. REC'D BY REGISTRAR <b>JUL 7 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |



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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09211

09211

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Baltimore</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Towson</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |  | d. STREET ADDRESS<br><b>606 Baltimore Avenue</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>TIMOTHY HERDL</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>26</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/20/67</b>                                 |
| 9. AGE (In years last birthday)<br><b>6 Days</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND Baltimore Co.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Paul Herdl</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNE CONFER</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no none</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>Family records</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7952</b> IMMEDIATE CAUSE (a) <b>Sudden unexpected death in infancy</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)      |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b>  |  | 22. DATE SIGNED<br><b>July 26, 1967</b>  |  |
| EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>  |  | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/28/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Marie</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Towson Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>John Burns Sons</b>  |  | 25a. REC'D BY REGISTRAR<br><b>610 York Rd.</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | DATE<br><b>JUL 31 1967</b>   |  |

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## CERTIFICATE OF DEATH

09212

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Reisterstown</u>   |   | c. LENGTH OF STAY IN 1b<br><u>Reisterstown</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>108 Chestnut Hill Lane</u>   |   | d. STREET ADDRESS<br><u>108 Chestnut Hill Lane</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>J.</u> Middle <u>Edward</u> Last <u>Hewes</u>   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>20</u> Year <u>19 67</u>   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 3, 1900</u>                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Vice President Union Trust Co.</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Union Trust Co.</u>   | 9. AGE (In years last birthday) yrs.<br><u>67</u>                       |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Balto. Co. Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>Charles K. Hewes</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Brandenburg</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.<br><u>218-03-1990</u>   |   |
| 17. INFORMANT<br><u>Mrs. Estelle S. Hewes</u>   |   | Address<br><u>Reisterstown, Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis</u><br>DUE TO (b) <u>Interval</u><br>DUE TO (c) <u>Interval</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Interval</u>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-1-59 to 7-20-67</u> , that (I) <u>was</u> last saw the deceased alive on <u>7-2-67</u> and that death occurred at <u>6:45</u> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><u>James G. Saffell</u> M.D.  |   | 22b. DATE SIGNED<br><u>7-20-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>James G. Saffell</u>   |   | 22d. ADDRESS<br><u>Reisterstown Md</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>July 22, 67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Dread Ridge Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Pikesville, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>J. F. Eline &amp; Sons</u>   |   | 25a. REC'D BY REGISTRAR<br><u>JUL 21 1967</u>   |   |
| ADDRESS<br><u>Reisterstown, Md.</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

36213

DEPARTMENT OF HEALTH

Germany

James G. Bell

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09213

## CERTIFICATE OF DEATH

09213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RANDALLSTOWN</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>BAH. COUNTY GEN. Hosp.</b>  |  | d. STREET ADDRESS<br><b>Dogwood Rd.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>John F. Hickey</b>   |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>15</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/24/1897</b>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MAINTENANCE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Woodlawn Cemetery</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Hickey</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>LAURA COLSON</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>215-24-124</b>  |  |
| 17. INFORMANT<br><b>Mrs Mary Hickey</b>  |  | Address<br><b>Dogwood Rd Baltimore MD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple peripheral pulmonary emboli - pulmonary infarcts</b><br>DUE TO (b) <b>Thrombosis of periprostatic &amp; pelvic veins</b><br>DUE TO (c) <b>Primary Ca of lung with metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Terminal</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-14</b> , 19 <b>67</b> , to <b>7-15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-15</b> , 19 <b>67</b> , and that death occurred at <b>1:02 PM</b> , from causes on and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>D. Simon</b>  |  | 22b. DATE SIGNED<br><b>7-15-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>D. SIMON</b>  |  | 22d. ADDRESS<br><b>Balti Co. Gen Hosp. Randallstown MD</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/18/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Alphonsus Church Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodstock Balto MD</b> |
| 24. FUNERAL DIRECTOR<br><b>Foring Byers 8728 Liberty Rd</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DATE JUL 18 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | 25c. REGISTRAR'S NAME<br><b>[Signature]</b>   |  |

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Multiple peripheral pulmonary emboli - internal  
thromboses of popliteal & pelvic veins  
Primary CA of lung with metastases

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JUL 18 1964

09214

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |   |   |  |   |   |   |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 wk.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkton #21120</b>                                    |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                  |   |   | d. STREET ADDRESS<br><b>Jordan Saw Mill Rd.<br/>Parkton, Maryland #21120</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Bisker Randolph Hollingshead</b>  |                                  |   |   | 4. DATE OF DEATH<br><b>July 10 1967</b>  |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 16, 1920</b> |  | 9. AGE (In years last birthday)<br><b>47 yrs.</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Watchman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Penna. Railroad</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Whitehall, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Bisker Hollingshead</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Viola</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>160-16-9311</b>   |   | 17. INFORMANT<br><b>Mrs. Mabel Hollingshead Parkton, Md 21120.</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory acidosis.</b><br>527.2<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypoventilation.</b><br>(c) <b>Obesity.</b> |                                  |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour "o.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1967</b> , to <b>July 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 10 1967</b> , and that death occurred at <b>6:35 AM</b> from causes and on the date stated above.  |                                  |   |   |  |   |   |   |
| 22a. SIGNATURE<br><b>M. S. Cockburn</b>   |                                  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>         |   | 22b. DATE SIGNED<br><b>July 10, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>M. S. Cockburn, M.D.</b>   |                                  |   |   | 22d. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>July 13, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West Liberty Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>White Hall, Md.</b>                           |   |
| 24. FUNERAL DIRECTOR<br><b>Jacob Hartenstein, New Freedom, Pa.</b>  |                                  |   |   | 25b. RECEIVED BY REGISTRAR<br><b>JUL 13 1967</b>   |   | 25c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

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|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY _____                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CLATONSVILLE</u>  |   | c. LENGTH OF STAY IN 1b<br><u>1 month</u>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE</u>   |   | d. STREET ADDRESS<br><u>1922 WILKENS AVE</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>16 Hastings Ave.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>WILLIAM</u> Middle <u>Howard</u> Last <u>HONEYCUTT</u>   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>29</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 24, 1908</u>                                    |
| 9. AGE (In years last birthday)<br><u>58</u> yrs.  |   | 10. IF UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS.: Hours _____ Min. _____   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FOREMAN</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>UTILITY CO.</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>TENNESSEE</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>CALVIN HONEYCUTT</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>SALLY TERRY</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u> <u>NONE</u>   |   | 16. SOCIAL SECURITY NO.<br><u>409-09-5695</u>   |   |
| 17. INFORMANT<br><u>ETHEL HONEYCUTT</u>  |   | Address<br><u>1922 WILKENS AVE.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardiovascular Disease</u><br>DUE TO<br>(c) _____ |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1201</u><br><u>530</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19 _____  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-23-</u> , 1967, to <u>7-29-</u> , 1967, that (I) (we) last saw the deceased alive on <u>7-28</u> , 1967, and that death occurred at <u>9:30 A.M.</u> , from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>Wilmer K. Gallagher</u>   |   | 22b. DATE SIGNED<br><u>7-31-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Wilmer K. Gallagher</u>   |   | 22d. ADDRESS<br><u>6209 Frederick Ave - Baltimore - 28, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>8-2-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LOUDON PARK</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE</u> <u>MD</u> |
| 24. FUNERAL DIRECTOR<br><u>Geo. L. Schwab Funeral Home</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 2 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Francis W. Miller 2101 Frederick Ave.</u>   |   | 25c. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

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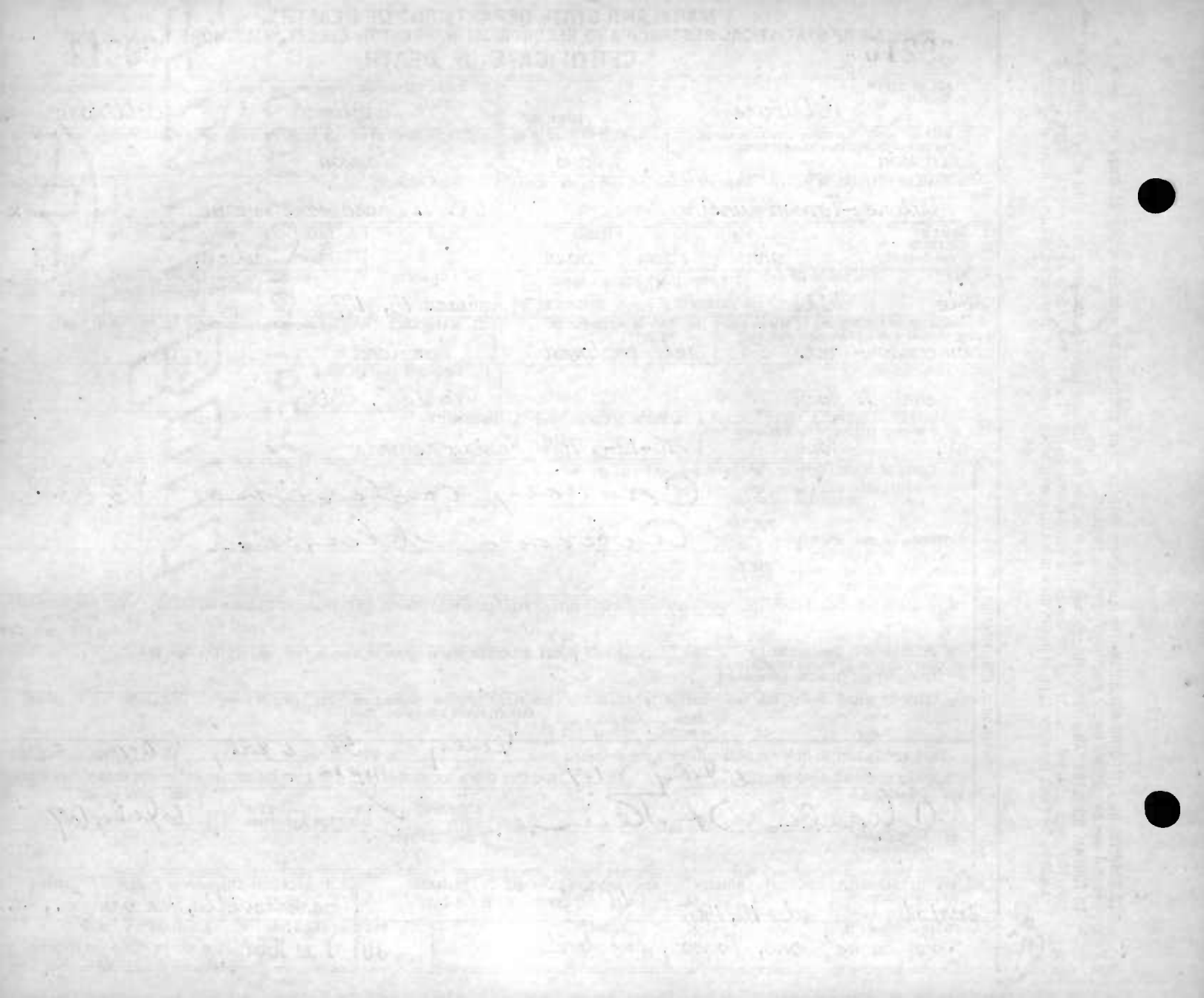
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> |   |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Towson</i>  |  |   | c. LENGTH OF STAY IN 1b<br><i>3 days</i>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Towson</i> <i>03-1</i>                                |   |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Dulaney-Towson Nursing Home</i>   |  |   |   |   | d. STREET ADDRESS<br><i>638 W. Chesapeake Avenue</i>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>John</i> Middle <i>Adam</i> Last <i>Horn</i>   |  |   | 4. DATE OF DEATH<br>Month <i>July</i> Day <i>6</i> Year <i>1967</i>                                       |   |  |   |  |   |  |  |  |
| 5. SEX<br><i>Male</i>  |  | 6. COLOR OR RACE<br><i>White</i>                          |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>January 15, 1975</i> |  | 9. AGE (In years last birthday)<br><i>92</i> yrs.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Stonemason - ret.</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Self employed</i> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>  |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |   |  |  |  |
| 13. FATHER'S NAME<br><i>Henry J. Horn</i>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><i>Annie C. Obitz</i>  |   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.<br><i>216-12-5078A</i>            |   | 17. INFORMANT<br><i>Family records</i>  |  |   | Address                                    |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary occlusion</i><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aortic - pleuritis</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 weeks</i>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)       |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>50</i> , to <i>6 July</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5 July</i> 19 <i>67</i> , and that death occurred at <i>12:10</i> AM, from the causes and on the date stated above.   |  |   |   |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><i>Charles H. Klein</i> M.D.   |  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |   |  | 22b. DATE SIGNED<br><i>6 July 67</i>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |   |   |   | 22d. ADDRESS   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |   | 23b. DATE THEREOF<br><i>July 10, 1967</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Old Salem Cemetery</i>  |   |  | 23d. LOCATION (City, town or county) (State)<br><i>Jarrettsville, Harford Co., Md.</i>            |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>John Burns' Sons, Towson, Maryland</i>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br><i>JUL 11 1967</i>  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09217

09217

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>   |  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PASADENA</b>   |  | d. STREET ADDRESS<br><b>57 Poplar Ridge Rd. Box 288A</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>BENDIX RADIO CORP.</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CORBIN</b> Middle <b>J</b> Last <b>HOUCK</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>12</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 25, 1916</b> 50 yrs.   |  |
| 9. AGE (In years, lost birthday)<br><b>50</b>   |  | IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>19</b> Hours <b>67</b>   |  | IF UNDER 24 HRS.<br>Months <b>12</b> Days <b>19</b> Hours <b>67</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sander</b> |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Milton Houck</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Sanks</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212-16-8654</b>  |  | 17. INFORMANT<br><b>Mrs. Jeanne Mills (daughter)</b>  |  | Address <b>Same As #2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b) <b>Coronary Insufficiency</b><br>DUE TO (c) <b>6 yrs</b>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.   |  |  |  | 22. DATE SIGNED   |  |   |  |
| EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>  |  |  |  | Address (Street, city, town, or county)   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |
| <b>Burnie</b>   |  | <b>July 15, 1967</b>   |  | <b>Glen Haven Memorial</b>  |  | <b>Glen Burnie, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>R.V. Singleton</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 13 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles F. O'Donnell</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09218

CERTIFICATE OF DEATH

09218

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Towson</u>  |   |
| c. LENGTH OF STAY IN 1b <u>4 Months</u>   |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria Rest Home</u>   |   | d. STREET ADDRESS <u>Glenarm Rd. Glenarm</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Sister M. Pietra Huckestein</u>  |   | 4. DATE OF DEATH <u>7 14 19 67</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-21-1894</u>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>  |   | 11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburg, Pa.</u>  |   |
| 10b. KIND OF BUSINESS OR INDUSTRY   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>  |   |
| 13. FATHER'S NAME <u>Peter Huckestein</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Margaret Reismann</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>   |   | 16. SOCIAL SECURITY NO. <u>218-54-1328-I1</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatous</u><br>DUE TO <u>170X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Brach adenocarcinoma</u><br>DUE TO<br>(c) |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>67</u> , to <u>7-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-10 1967</u> , and that death occurred at <u>7-10</u> M, from causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>Henry L McCorkle</u>  |   | 22b. DATE SIGNED <u>7-21-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY L MCCORKLE MD</u>   |   | 22d. ADDRESS <u>Phoenix Maryland 21131</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>July 18, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Glen Arm, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Raymond J. Curran</u> ADDRESS <u>817 Scarlett Dr. Towson, Maryland 21204</u>  |   | 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE   |   |
|   |   | DATE <u>JUL 25 1967</u>  |   |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

| <div>Item 20 Film 390 7-13-67 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>09218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09218</div>  |  |                              |  |   |  |  |  |   |   |   |   |  |
|--|--|------------------------------|--|---|--|--|--|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |                              |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Town</b>  |  |                              |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  |   |   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  |                              |  |   |  | d. STREET ADDRESS<br><b>4806 Liberty Heights Ave.</b>  |  |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Gertrude H Hughes</b>  |  |                              |  |   |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>5</b> Year <b>19 67</b>  |  |   |   |   |   |  |
| 5. SEX<br><b>F</b>   |  | 6. COLOR OR RACE<br><b>W</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH<br><b>4/24/03</b>   |  | 9. AGE (In years lost birthday)<br><b>64</b> yrs. |   | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School Teacher</b>   |  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |   |   |  |
| 13. FATHER'S NAME<br><b>Henry Fenzel</b>   |  |                              |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Kreigenhofer</b>  |  |   |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |                              |  | 16. SOCIAL SECURITY NO.<br><b>214-40-4560</b>   |  | 17. INFORMANT<br><b>Mrs. Wm. D. Ruff-Baltimore, Md. 21207</b>  |  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>812.4</b> IMMEDIATE CAUSE (a) <b>Crushing injury to chest</b><br>DUE TO (b) <b>4 hrs.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)  |  |                              |  |   |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                              |  |   |  |  |  |   |   |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                              |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Standing behind auto that moved backward and ran over her.</b> |  |  |  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>10 00</b> Hour <b>a.m.</b> <b>July 5 19 67</b>  |  |                              |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Parking lot</b>   |  |   | 20f. (City or town) (County) (State)<br><b>Balto. Md.</b>             |   |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                              |  |   |  |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b> M.D.   |  |                              |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |   |   |  |
| EXAMINER'S NAME (Type)<br><b>CHARLES F. O'DONNELL, M.D.</b>  |  |                              |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |   |   |  |
|  |  |                              |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |   |   |  |
|  |  |                              |  |   |  | Address (Street, city, town, or county)  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                              |  | 23b. DATE THEREOF<br><b>July 10 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Harry A. Armascio</b> 4204  |  |                              |  |   |  | ADDRESS<br><b>Ridgewood Ave. Baltimore, Md.</b>  |  |   | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1967</b>                         |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles F. O'Donnell</b> |  |

2132

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U.S. AIR FORCE  
HONOLULU, HAWAII

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|   |  |  |  |
|---|--|--|--|
| 09220   |  | 09220  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex</b><br>c. LENGTH OF STAY IN 1b<br><b>years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>2100 Tred-Avon Rd.</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex</b><br>d. STREET ADDRESS<br><b>2100 Tred-Avon Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Agnes Victoria Hunter</b><br>s. SEX<br><b>Female</b><br>6. COLOR OR RACE<br><b>Caucasian</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steam Table Operator</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br><b>Glen L. Martin</b><br>11. BIRTHPLACE (State or foreign country)<br><b>Annapolis, Md.</b><br>12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1967</b><br>9. AGE (In years last birthday) yrs. <b>72</b><br>IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.<br>13. FATHER'S NAME<br><b>William D. K. Lee</b><br>14. MOTHER'S MAIDEN NAME<br><b>Mary Larrimore</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-26-3799</b><br>17. INFORMANT<br>Address<br><b>Mrs. Elizabeth A. Sternberg, Balto. 29, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO (b) <b>ACVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Theo C. Patterson</b> M.D.<br>EXAMINER'S NAME (Type)<br>22. DATE SIGNED<br><b>7/2/67</b>  |  | 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>23b. DATE THEREOF<br><b>July 5, 1967</b><br>23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cath. Cem</b><br>23d. LOCATION (City or Town) (County) (State)<br><b>Annapolis, Anne Arundel, Md</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles F. Bell, Jr.</b><br><b>Hopping F.H. 172 West St. Annapolis, Md</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 6 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09221

09221

CERTIFICATE OF DEATH

|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>13-1</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>118 Fairfield Drive</b>   |                                  | d. STREET ADDRESS<br><b>118 Fairfield Drive</b>   |                                     |
| 3. NAME OF DECEASED<br>(Type or print) <b>William P. Ihrie</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>13</b> Year <b>19 67</b>   |                                     |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-4-1884</b> |
| 9. AGE (In years last birthday) yrs.<br><b>82</b>  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS. Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>John Ihrie</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Edith Jones</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>216-05-8102</b>   |                                     |
| 17. INFORMANT<br><b>Paul D. Ihrie, 5902 Roland Ave. 21210</b>  |                                  | Address   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4221</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Heart</b> |                                  |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus</b>   |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19 p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 19 57</b> to <b>July 13, 19 67</b> , that (I) (we) last saw the deceased alive on <b>July 13, 19 67</b> , and that death occurred at <b>5 A</b> M, from causes and on the date stated above.  |                                  |   |                                     |
| 22a. SIGNATURE<br><b>James E. Rowe</b>   |                                  | 22b. DATE SIGNED<br><b>7/13/67</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. James Rowe</b>   |                                  | 22d. ADDRESS<br><b>5550 Baltimore National Pike</b>   |                                     |
| 23a. 8 BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>7-15-1967</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 17 1967</b>   |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                  | 25c. REGISTRAR'S ADDRESS  |                                     |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09222

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09222

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Timonium</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>years</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>19 Sam Will Avenue</b>   |                                  | e. STREET ADDRESS<br><b>19 Sam Will Avenue</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>EDWIN LEE IRETON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>28</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>February 10, 1910</b><br>AGE (In years last birthday) <b>57</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Black and Decker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tool Maker</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Webb, Dewey Co. Oklahoma</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Winfield Scott Ireton</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alvira Frances Shaner</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>567-07-2708</b>  |   |
| 17. INFORMANT<br><b>Mrs. Violet M. Ireton,</b>  |                                  | Address<br><b>Same as # 2</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4201</b><br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b) <b>Sudden</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c)   |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                      |
| 20f. (City or town) (County) (State)  |                                  |  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b><br>EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell, M.D.</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><b>7/28/67</b> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>July 31, 1967</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson,</b><br>ADDRESS<br><b>1050 York Road Towson, Maryland 21204</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 31 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>1mth5dys</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>West Hyattsville, Maryland</b>  |                                  | d. STREET ADDRESS<br><b>3501 Toledo Terrace</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>S.</b> Last <b>Jackson</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>14</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 28, 1907</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>60</b>  |                                  | IF UNDER 1 YEAR<br>Months <b>14</b> Days <b>19</b> Hours <b>67</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>warehouse manager</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>freight</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>William</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Thompson</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHOPNEUMONIA</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>June 7, 1967</b> , to <b>July 14, 1967</b> , that <b>he</b> (we) last saw the deceased alive on <b>July 14, 1967</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.                  |                                  |   |  |
| 22a. SIGNATURE<br><b>Vicente M. Rucio</b>  |                                  | 22b. DATE SIGNED<br><b>7-15-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>VICENTE M. RUCIO</b>  |                                  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>July 18, 1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colman Manor Park Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>J. Arthur Dallas</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>254 Carroll St. at West 4th</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |                                  | DATE<br><b>JUL 17 1967</b>  |  |

STATE OF MISSISSIPPI  
DEPARTMENT OF REVENUE

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Your Obedient Servant

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 09224  |  | 09224   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  | c. LENGTH OF STAY IN It  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore, 21224</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  | d. STREET ADDRESS<br><b>405 S. Robinson St.</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <b>DANIEL J. JACOBS, Sr.</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>14</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 19, 1892</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired American Smelting &amp; Refining Co.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Refining</b>  | 9. AGE (In years lost birthday) <b>75</b> yrs.  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Frederick Jacobs</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret J. Wagner</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-10-3745</b>   |   |
| 17. INFORMANT<br><b>Mrs. Estelle Jacobs wife, above</b>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1992</b> IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c) |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>June 30, 1967</b> , to <b>July 14, 1967</b> , that <b>he</b> (we) lost saw the deceased alive on <b>July 14, 1967</b> , and that death occurred at <b>6:40 PM</b> , from causes and on the date stated above.           |  |   |   |
| 22a. SIGNATURE<br><b>Joel V. Tolentino</b>   |  | 22b. DATE SIGNED<br><b>7/14/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Joel V. Tolentino, M.D.</b>   |  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Type)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/18/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 18 1967</b>   |   |
| ADDRESS<br><b>3331 Brehms Lane</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09225

## CERTIFICATE OF DEATH

09225

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Garrison Md.</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>144</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Forleigh Nursing Home</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ROSE</u> Middle Last <u>Jacobs</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>2</u> Year <u>1967</u>  |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>[REDACTED]</u>                                      |  |
| 9. AGE (In years last birthday)<br><u>79</u> yrs.   |  | 10. UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |  | 11. UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Teacher + Housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>   |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>U.S.A. Baltimore, Maryland</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>S.A.</u>   |  |  |  |
| 13. FATHER'S NAME<br><u>Louis Simon</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Lenora Singer</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>215-56-1804</u>   |  | 17. INFORMANT<br><u>Mrs. Joanne Solomon, Great Neck, L.I.N.Y.</u>          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>446X</u><br>DUE TO (b) <u>Uremia</u><br>DUE TO (c) <u>Nephrosclerosis</u><br>Arteriosclerosis   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u><br><u>unknown</u><br><u>unknown</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>67</u> , to <u>7-2</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>7-1</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>David I Miller</u> M.D.  |  |   |  | 22b. DATE SIGNED<br><u>7-2-67</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>David I Miller</u>                      |  |
| 22d. ADDRESS<br><u>Linson Rd. Owings Mills, Md</u>  |  |   |  | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>July 4, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Chizuk Amuno</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Baltimore, Maryland</u> |  |
| 24. FUNERAL DIRECTOR<br><u>Sol Levinson &amp; Bros. 6010 Reisterstown Road</u>  |  |   |  | 25a. REC'D BY REGISTRAR<br><u>JUL 7 1967</u>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  | 25c. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

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Ministry of Education

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |   |
|--|--|--|--|--|---|--|--|--|---|
| 09226 CERTIFICATE OF DEATH 09226   |  |  |  |  |   |  |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> |  |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Md.</u>  |  |  |  |   |
| c. LENGTH OF STAY IN 1b <u>14 days</u>   |  |  |  |  | d. STREET ADDRESS <u>2303 Springlake Dr.</u>  |  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>  |  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print) <u>Grace Virginia Johnson</u>  |  |  |  |  | 4. DATE OF DEATH <u>July 3 1967</u>   |  |  |  |   |
| 5. SEX <u>Female</u>   |  |  |  |  | 6. COLOR OR RACE <u>Cau.</u>  |  |  |  |   |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 8. DATE OF BIRTH <u>4-29-19</u>   |  |  |  |   |
| 9. AGE (In years last birthday) <u>48</u> yrs.   |  |  |  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |  |  |   |
| 13. FATHER'S NAME <u>James Finno</u>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Lillian Dondero</u>   |  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  |  |  |  | 16. SOCIAL SECURITY NO. <u>103-07-2633</u>  |  |  |  |   |
| 17. INFORMANT <u>J. Fred Johnson</u>   |  |  |  |  | Address <u>same as 2</u>  |  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of the Breast (carcinoma)</u><br>170x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis (multiple)</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>13 days</u><br><u>2 months</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |   |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                    |  |  |  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  | 20f. (City or town) (County) (State)  |  |  |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>July 3 1967</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.   |  |  |  |  |   |  |  |  |   |
| 22a. SIGNATURE <u>[Signature]</u>  |  |  |  |  | 22b. DATE SIGNED <u>July 3 1967</u>   |  |  |  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. A. MONTAGUE</u>  |  |  |  |  | 22d. ADDRESS <u>MEDICAL ARTS BUILDING</u>   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  |  | 23b. DATE THEREOF <u>July 7, 1967</u>   |  |  |  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>  |  |  |  |  | 23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u>  |  |  |  |   |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Town</u>   |  |  |  |  | 25a. REC'D BY REGISTRAR <u>1050 York Rd. 21204</u>  |  |  |  |   |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |  |  |  | DATE <u>JUL 10 1967</u>   |  |  |  |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09227

09227

|   |                              |   |   |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perry Hall</b>   |                              | c. LENGTH OF STAY IN lb<br><b>15 yr</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>4117 K. Lawrence Rd</b>  |                              | d. STREET ADDRESS<br><b>4117 K. Lawrence Rd</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Mabel Elizabeth Johnson</b>   |                              | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>27 July 1897</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>69</b>   |                              | 10. UNDER 1 YEAR<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Housewife</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Frank King</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Annie Dean</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Mr. Lawrence G. Johnson</b>   |                              | Address<br><b>same address</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4221</b><br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO (b) <b>Chronic Bronchitis</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus, Chronic Bronchitis, Peptic ulcer</b>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |   |
| ACTUAL SIGNATURE<br><b>John C. Hyle</b>   |                              | 22. DATE SIGNED<br><b>7-10-67</b>   |   |
| EXAMINER'S NAME (Type)<br><b>JOHN C. HYLE</b>   |                              | Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>7/14/1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Faith Cemetery</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Tickner Sons</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>JUL 18 1967</b>   |   |
| Address<br><b>Baltimore, Md.</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

09228

**CERTIFICATE OF DEATH**

09228

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |   |  |  |   |   |   |
|--|----------------------------------|---|--|--|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort Howard</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>53 Days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Salisbury</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Veterans Administration Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>502 Woodlyn Street</u>   |   |   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>ARTHUR WILLIAM JONES</u>  |                                  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>July</u> Day <u>1</u> Year <u>1967</u>   |   |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 16, 1916</u>                               |  | 9. AGE (In years last birthday) yrs.<br><u>50</u> | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cook</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Canning Factory</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Westover, Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Willie Jones</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Collier</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes WW-11</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>214 18 44 19</u>  |  | 17. INFORMANT Address<br><u>Clinical Reds VA Hospital, Fort Howard, Md.</u>  |   |   |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u><br><u>442X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE WITH UREMIA</u><br>(c) <u>BENIGN PROSTATIC HYPERTROPHY</u> |                                  |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>RECENT</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19____  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)              |   |   |
| 21. I certify that <u>Dr. (this hospital)</u> attended the deceased from <u>May 9</u> , 19 <u>67</u> , to <u>July 1</u> , 19 <u>67</u> that <u>Dr. (we)</u> last saw the deceased alive on <u>July 1</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.  |                                  |   |  |  |   |   |   |
| 22a. SIGNATURE<br><u>Peter V. Juvan</u>  |                                  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                    |   | 22b. DATE SIGNED<br><u>7/3/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>PETER V. JUVAN, M.D.</u>  |                                  |   |  | 22d. ADDRESS<br><u>VA Hospital, Fort Howard, Md.</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>7/8/67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Carmel Baptist Church</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Princess Anne Maryland</u>                    |   |
| 24. FUNERAL DIRECTOR<br><u>William H James Jr</u>  |                                  |   |  | ADDRESS<br><u>Princess Anne, Maryland</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 7 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Juvan</u>   |                                  |   |  |  |   |   |   |

1710

STATE OF OHIO

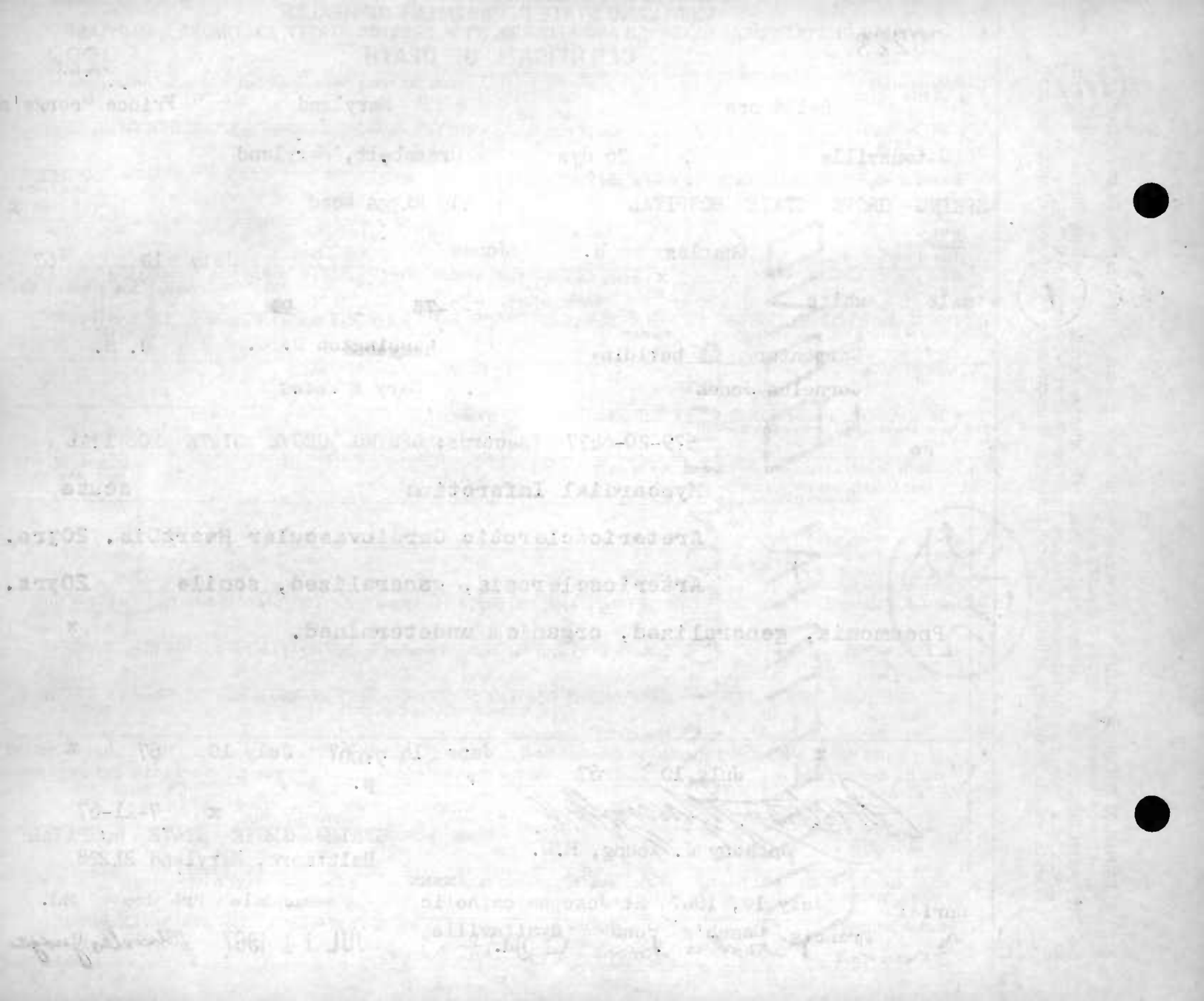
1710

IN SENATE,  
January 1, 1880.  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE,  
MAY 1, 1879.  
COLUMBUS:  
PUBLISHED BY  
THE STATE OF OHIO,  
1880.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |   |   |  |                                |   |   |  |
|--|--|-------------------------------|---|---|--|--------------------------------|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |   |   |  |                                |   |   |  |
| CERTIFICATE OF DEATH   |  |                               |   |   |  |                                |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b <b>26 dys</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>   |  |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, Maryland</b><br>d. STREET ADDRESS <b>410 Riggs Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>H.</b> Last <b>Jones</b>   |  |                               |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>1967</b>   |                                |   |   |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>white</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>7-2-78</b> |   | 9. AGE (In years last birthday) <b>91</b> yrs.<br>IF UNDER 1 YEAR: Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>   |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>building</b>   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>  |                                |   | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>   |  |
| 13. FATHER'S NAME <b>Cornelius Jones</b>   |  |                               |   |   | 14. MOTHER'S MAIDEN NAME <b>Mary E Gates</b>   |                                |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  |                               | 16. SOCIAL SECURITY NO. <b>579-20-6477</b>  |   | 17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>  |                                |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Heart Dis. 20yrs.</b><br>DUE TO (c) <b>Arteriosclerosis, generalized, senile 20yrs.</b> |  |                               |   |   |  |                                |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia, generalized, organism undetermined.</b>  |  |                               |   |   |  |                                |   |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |                                |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.  |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                | 20f. (City or town) (County) (State)                                      |   |  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>June 14, 1967</b> , to <b>July 10, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>July 10, 1967</b> , and that death occurred at <b>P.</b> M, from the causes and on the date stated above.   |  |                               |   |   |  |                                |   |   |  |
| 22a. SIGNATURE <b>Anthony J. Young, M.D.</b>   |  |                               |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                                |   | 22b. DATE SIGNED <b>7-11-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>   |  |                               |   |   | 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL, Baltimore, Maryland 21228</b>   |                                |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                               | 23b. DATE THEREOF <b>July 14, 1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>St Josephs catholic</b>  |                                | 23d. LOCATION (City, town or county) (State) <b>Ammondale Pro Geo Md.</b> |   |  |
| 24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>   |  |                               |   |   | ADDRESS <b>Hyattsville Md.</b>   |                                | 25a. REC'D BY REGISTRAR <b>JUL 14 1967</b>                                |   |  |
|  |  |                               |   |   |  |                                | 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>                           |   |  |



09230

## CERTIFICATE OF DEATH

09230

|  |                                  |   |  |  |   |   |                                |
|--|----------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |   | b. COUNTY<br><b>Baltimore</b>   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cockeysville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>7</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cockeysville</b>              |   | <b>231</b>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Box 169 Beaver Dam Road</b>   |                                  |   |  | d. STREET ADDRESS<br><b>Box 169 Beaver Dam Road</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Alfred Monroe Joslin</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 3 1967</b>   |   |   |                                |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 20, 1906</b> |  | 9. AGE (In years last birthday)<br><b>61</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Proof-Reader</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>                                    |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13. FATHER'S NAME<br><b>John A. Joslin</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lillian Kirby</b>   |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>212-03-7279</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Mabel Joslin Same as 2</b>   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO <b>Arteriosclerotic Heart Disease</b><br>(c) <b>Years -</b> |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>  |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  |   |   |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.   |                                  |   |  |  |   |   |                                |
| 22a. SIGNATURE<br><b>Robert W. Edmonds</b> M.D.  |                                  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>July 6, 1967</b>   |                                |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert W. Edmonds</b>   |                                  |   |  | 22d. ADDRESS   |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>July 6, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem'l. Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville, Balt. Maryland</b>                 |                                |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson</b>  |                                  |   |  | ADDRESS<br><b>1050 York Road Towson, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 10 1967</b>  |                                |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

1903

Know all men by these presents, that I, John A. Smith, of the County of Dallas, State of Texas, for and in consideration of the sum of Five Dollars, to John A. Smith in hand paid by John A. Smith, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said John A. Smith, all that certain Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, as the same may appear by the plat of said land, to said John A. Smith, his heirs and assigns forever.

Cardinal Arrest  
Myocardial Infarction  
Atherosclerotic Heart Disease

John A. Smith

Witness my hand and seal of office this 1st day of January, 1903, at Dallas, Texas.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardboq papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09231

CERTIFICATE OF DEATH

09231

|   |                                     |   |  |   |  |   |  |
|---|-------------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b><br>c. LENGTH OF STAY IN 1b<br><b>031</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1123 Granville Rd.</b>  |                                     |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b><br>d. STREET ADDRESS<br><b>1123 Granville Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Beatrice B. Judy</b>   |                                     |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 8, 19 67</b>  |  |   |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>Cauc.</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/13/20</b>                                     |   | 9. AGE (In years last birthday)<br><b>47</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>N. C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Bullock</b>   |                                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>-----</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mr. Charles Judy</b><br><b>1123 Granville Rd.</b><br>Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO<br>416X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RHEUMATIC HEART DISEASE</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>3 YRS</b> |                                     |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                     |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)               |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11</u> , 1958, to <u>July 8</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 29</u> 1967, and that death occurred at <u>5A</u> M. from causes on and on the date stated above.  |                                     |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Kennard Yaffe</b>  |                                     | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>7/10/67</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Kennard Yaffe, M. D.</b>   |                                     | 22d. ADDRESS<br><b>5501 Forest Park Av.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/11/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke F. D. - 4101 Edmondson Ave.</b>   |                                     |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 1967</b>                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |  |

DEPARTMENT OF HEALTH

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Baltimore County</u> , MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Pikesville Md.</u>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RAVANA TOWN</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>PIKESVILLE</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Baltimore General Hosp.</u>  |  | d. STREET ADDRESS<br><u>6 Orchard Bl. 21208</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>ISAIAH CHARLES KAUFFMAN</u>  |  | 4. DATE OF DEATH<br>Month <u>JULY</u> Day <u>3</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug. 20, 1902</u>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>ATP</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>PENNSYLVANIA</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Lewis Kauffman</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Blizard</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>218-07-4572</u>   |  |
| 17. INFORMANT<br><u>Alfred Kauffman</u>   |  | Address<br><u>Same</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Cong. Heart Failure, A.S.C.V.D.</u><br>DUE TO (b) <u>Myocardial Infarction</u><br>DUE TO (c) <u>Coronary Heart Disease</u>      |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 HOURS</u><br><u>2</u><br><u>1 YR</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><u>NEPHROLITHIASIS</u>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 11, 1951</u> , to <u>July</u> , 1967, that (I) (we) last saw the deceased alive on <u>2 July</u> , 1967, and that death occurred at <u>8:38 A.M.</u> from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><u>Charles H. Williams</u>  |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles H. Williams, MD</u>   |  | 22d. ADDRESS <u>Pikesville 21208, Md.</u>   |  |
| 23a. BURIAL, CREMATION, or MOVING (Specify)   |  | 23b. DATE THEREOF   |  |
| <u>Burial</u>   |  | <u>July 6, 1967</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |
| <u>Evergreen Memorial Park, Pikesville, Md.</u>   |  | <u>Pikesville, Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Howell Funeral Home, Pikesville, Md.</u>   |  | 25. FILED BY REGISTRAR<br><u>JUL 11 1967</u>  |  |
| 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  | DATE  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09233

09233

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |  | c. LENGTH OF STAY IN lb<br><b>10 yrs</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3020 Wallford Drive</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>William Keith</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 7 1967</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>5/28/16</b>                                     |
| 9. AGE (In years last birthday)<br><b>51 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Electrician - Retired</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 13. FATHER'S NAME<br><b>William Keith</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Shelby Rhodes</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>228-18-5750</b>  |  | 17. INFORMANT<br>Address <b>Dundalk, Md.</b><br><b>Mrs. Martha Keith, 3020 Wallford Dr.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer, Right Lung c</b><br>DUE TO (b) <b>Metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                            |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mos.</b>                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b><br>EXAMINER'S NAME (Type)   |  | 22. DATE SIGNED<br><b>7-8-67</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 Morningson Rd.</b><br>Address (Street, city, town, or county) <b>Dundalk, Md.</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/10/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 09234  |  | 09234   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore Co.</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |  | c. LENGTH OF STAY IN lb<br><u>Baltimore 21204</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Greater Balto Medical Center.</u>   |  | d. STREET ADDRESS<br><u>220 Maryland Ave</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Frank A Lousius Kelly</u>  |  | 4. DATE OF DEATH<br>Month <u>7</u> - Day <u>16</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-27-96</u>                                     |
| 9. AGE (In years lost birthday) yrs. <u>71</u>   |  | 10. IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>16</u> Hours <u>19</u> Min. <u>67</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Supervisor Gas &amp; Elec. Co.</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Baltimore, Md.</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Edward Franklin Kelly</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Bangs</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes WW1</u>   |  | 16. SOCIAL SECURITY NO.<br><u>212-05-4961</u>   |  |
| 17. INFORMANT<br><u>Patient's Chart.</u>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pericarditis</u><br>DUE TO (b) <u>Wound infection after laryngectomy and esophagotomy</u><br>stating the underlying cause last. (c) <u>for carcinoma</u> |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>AS CVD</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>0</u> a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 5, 1967</u> to <u>July 16, 1967</u> that (we) last saw the deceased alive on <u>July 16, 1967</u> and that death occurred at <u>4:00 PM</u> , from cause <u>as stated above</u> and on the date stated above.             |  |   |  |
| 22a. SIGNATURE<br><u>Keiffer J. Mitchell</u> M.D.  |  | 22b. DATE SIGNED<br><u>7-16-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Keiffer J. Mitchell</u>   |  | 22d. ADDRESS<br><u>G.B.M.C.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>7/19/67.</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Balto. National Cem.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 17 1967</u>  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                     |  |   |  |   |  |   |  |   |  |
|--|--|-------------------------------------|--|---|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                     |  |   |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |                                     |  |   |  |   |  |   |  |   |  |
| 09235  |  | 09235                               |  |   |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Md. 21234</b> b. COUNTY <b>Balto</b> |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  |                                     |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                                      |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>St. Joseph's Hospital</b>   |  |                                     |  |   |  | d. STREET ADDRESS<br><b>1703 Aberdeen Rd.</b>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Robert</b> Last <b>Kerns</b>  |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>19 67</b>  |  |   |  |   |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5/20/97</b>  |  | 9. AGE (In years last birthday)<br><b>70 yrs.</b>                       |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Food Supervisor (ret.)</b>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Army Airforce Exchange Va.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 13. FATHER'S NAME<br><b>Harrison Kerns</b>   |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |  |                                     |  |   |  | 16. SOCIAL SECURITY NO.<br><b>212-07-0834</b>   |  | 17. INFORMANT <b>8240 Loch Raven Blvd. Lillian Creamer Kerns, wife,</b> |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture abdominal Aorta Aneurysm</b><br>DUE TO (b) <b>Abdominal Aorta Aneurysm</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                                     |  |   |  |   |  |   |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH   |  |                                     |  |   |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                     |  |   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>June 19 1967</b> , and that death occurred at _____ M, from the causes and on the date stated above.  |  |                                     |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Rafael Hernandez</b>  |  |                                     |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>                                  |  | STAFF PHYS. <input type="checkbox"/>      |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Rafael Hernandez</b>  |  |                                     |  |   |  | 22d. ADDRESS<br><b>8155 Hook Road Balto Md.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/12/67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Md.</b>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  |                                     |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jones</b>                   |  |   |  |
| 3331 Brehms Lane   |  |                                     |  |   |  |   |  |   |  |   |  |

W. 21234  
Baltimore

1705 Aberdeen Rd.

July

70

1705/07

Food supervisor (ret) Army Air Force Exchange, VA.

unknown

Marion Keene

1705/07 212-17-0004 William Keene, wife.

Baltimore, Md.

Baltimore, Md.

1705/07

Marion

Schlemmer General Food, Inc.  
2831 Briggs Lane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09236

CERTIFICATE OF DEATH

09236

|   |                                  |   |                                      |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY                           |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>30.4</b>  |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b>   |                                  | d. STREET ADDRESS<br><b>1249 Meridene Dr., 21212</b>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Chesapeake Manor Nursing Home</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Louise Catherine Killman</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 2 19 67</b>   |                                      |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/10/1889</b> |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Henry Paul</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Wacker</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>217-14-1296D</b>  |                                      |
| 17. INFORMANT<br><b>Mrs. Carolyn Correa</b>   |                                  | Address<br><b>1249 Meridene Dr.</b>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL COMA</b><br>DUE TO <b>CEREBROVASCULAR ACCIDENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b><br>(c) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS</b><br><b>1 DAY</b><br><b>YEARS</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>RECENT FRACTURE NECK OF FEMUR.</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1967</b> to <b>July 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 2, 1967</b> , and that death occurred at <b>5:30 P.</b> M, from causes and on the date stated above.  |                                  |   |                                      |
| 22a. SIGNATURE<br><b>Enrique Moszkowski</b>   |                                  | 22b. DATE SIGNED<br><b>7-3-67</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Enrique Moszkowski</b>   |                                  | 22d. ADDRESS<br><b>Caves &amp; Hudson Road</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/5/67</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore County Md.</b>  |                                      |
| 24. FUNERAL DIRECTOR<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE JUL 5 1967</b>   |                                      |
| ADDRESS<br><b>4905 York Road 21212</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John C. Judge</b>  |                                      |

93:001

1945



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                    |  |   |  |   |  |  |  |   |  |
|---|--|------------------------------------|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                    |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |                                    |  |   |  |   |  |  |  |   |  |
| 10655   |  |                                    |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |                                    |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>-</u>          |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |                                    |  |   |  | c. LENGTH OF STAY IN 1b<br><u>4 days</u>  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Greater Baltimore Medical Center</u>   |  |                                    |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Balto</u>  |  |  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                    |  |   |  | d. STREET ADDRESS<br><u>3004 Christopher Ave</u>  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Katie</u> Middle <u>Kingsbury</u> Last <u>-</u>   |  |                                    |  |   |  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>30</u> Year <u>1967</u>   |  |  |  |   |  |
| 5. SEX<br><u>F</u>  |  | 6. COLOR OR RACE<br><u>W</u>       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1/23/86</u>  |  | 9. AGE (In years last birthday)<br><u>81</u> yrs.                                  |  | IF UNDER 1 YEAR<br>Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Balto MD</u>             |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>-</u>                                      |  |
| 13. FATHER'S NAME<br><u>Geo Jefferies</u>   |  |                                    |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Kate Whitehead</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>-</u>   |  |                                    |  |   |  | 16. SOCIAL SECURITY NO.<br><u>-</u>   |  |  |  |   |  |
| 17. INFORMANT<br><u>Mrs Coe</u>   |  |                                    |  |   |  | Address<br><u>3004 Christopher</u>  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u><br>163X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <u>-</u><br>DUE TO (c) <u>-</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                    |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>-</u>                                |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>-</u>   |  |                                    |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>-</u> |  | 20f. (City or town) (County) (State)<br><u>-</u>                              |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> , 1967, to <u>July 30</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 30</u> , 1967, and that death occurred at <u>12:05M</u> , from the causes and on the date stated above.   |  |                                    |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>John E. Adams</u>  |  |                                    |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><u>July 30, 1967</u>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John E. Adams, M.D.</u>  |  |                                    |  |   |  | 22d. ADDRESS<br><u>Greater Baltimore Medical Center</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>8/2/67</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Louisa Park</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Balto</u>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>A Heemann</u>  |  |                                    |  |   |  | ADDRESS<br><u>6067 Harford Rd</u>   |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                            |  |
| DATE<br><u>AUG 8 1967</u>   |  |                                    |  |   |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09238

09237

|  |                           |  |                                      |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                   |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                           | c. LENGTH OF STAY IN 1b<br><b>20.4</b>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Dulaney-Towson N. H.</b>  |                           | d. STREET ADDRESS<br><b>5816 Northwood Dr.</b>   |                                      |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |                                      |
| 3. NAME OF DECEASED<br>(Type or print) <b>William H. Kinnear</b>   |                           | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>21</b> Year <b>1967</b>   |                                      |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>8-19-1895</b> |
| 9. AGE (In years last birthday) yrs. <b>71</b>   |                           | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>  |                                      |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Police Dept.</b>   |                           | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                           | 13. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland (Balto. City)</b>   |                                      |
| 13. FATHER'S NAME<br><b>William M. Kinnear</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>Florence Ohle</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>  |                           | 16. SOCIAL SECURITY NO.<br><b>212-38-1257</b>  |                                      |
| 17. INFORMANT<br><b>William Henry Kinnear</b>  |                           | Address<br><b>Above</b>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of liver.</b><br>DUE TO <b>Hepatic Cysticosis with ascites</b><br>(b) <b>Hepatorenal syndrome.</b><br>DUE TO <b>Acute heart failure and death</b><br>(c) <b>1561</b> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks.</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>27 June 1967</b> to <b>22 July 1967</b> , that (I) (we) lost<br>saw the deceased alive on <b>22 July 1967</b> and that death occurred at <b>9:40 PM</b> , from causes on the date stated above.   |                           |  |                                      |
| 22a. SIGNATURE<br><b>Joseph E. Muse Jr.</b>  |                           | 22b. DATE SIGNED<br><b>23 July 67</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Joseph E. Muse</b>  |                           | 22d. ADDRESS<br><b>2725 N. Charles St. Balto. Md.</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 23b. DATE THEREOF<br><b>7-24-67</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>  |                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Balto. Md.</b>  |                                      |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |                           | 25a. REC'D BY REGISTRAR<br><b>JUL 24 1967</b>  |                                      |
| ADDRESS<br><b>4905 York Rd., Balto</b>   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Richard Judge</b>   |                                      |

DEPARTMENT OF DEATH

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY                              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Baltimore 21212</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  | d. STREET ADDRESS<br><b>5509 The Alameda</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>EVELYN R. KIRCHHEINER</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>11</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 14, 1901</b>                              |
| 9. AGE (In years lost birthday) yrs.<br><b>65</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>William H. Lamm</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah McClain</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>--</b>  |   |
| 17. INFORMANT<br><b>Louis Kirchheiner</b>  |  | Address<br><b>Above</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive acute myocardial infarction</b><br>DUE TO <b>thrombosis of main right coronary artery.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>July 9,</b> 19 <b>67</b> , to <b>July 11,</b> 19 <b>67</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>July 11</b> 19 <b>67</b> , and that death occurred at <b>8:10 PM</b> , from causes and on the date stated above.                                       |  |   |   |
| 22a. SIGNATURE<br><b>Reynaldo Orjuela Gomez, M.D.</b>  |  | 22b. DATE SIGNED<br><b>7/12/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS<br><b>7620 York Road, Baltimore, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7-15-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 13 1967</b>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u><br>c. LENGTH OF STAY IN 1b <u>28 yrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5646 Carville Ave</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u><br>d. STREET ADDRESS <u>5646 Carville Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Gertrude A. Kenny Klein</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>July</u> Day <u>4</u> Year <u>1967</u>  |  |  |  |   |  |
| <b>5. SEX</b><br><u>F</u>   | <b>6. COLOR OR RACE</b><br><u>W</u>  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>July 12, 1898</u>                      | <b>9. AGE</b> (In years last birthday) <u>68</u> yrs.  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>                      | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Funeral Director</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Funeral</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Balto. City, Md.</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>      |  |
| <b>13. FATHER'S NAME</b><br><u>George Thornton</u>  |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Minna Kelly</u>                |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>215-07-2541</u>  |  | <b>17. INFORMANT</b><br><u>Jack McManus (son)</u>  |  | <b>Address</b><br><u>5646 Carville Ave.</u>               |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>4201 DUE TO <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(c) <u>  </u><br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>  </u>      |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. <u>  </u> p.m. <u>19</u>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |  | <b>20f. (City or town)</b><br><u>  </u>  | <b>(County)</b><br><u>  </u>   | <b>(State)</b><br><u>  </u>                               |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 4, 1964</u> <b>to</b> <u>July 4, 1967</u> ; <b>that (I) (we) last saw the deceased alive on</b> <u>June 7, 1967</u> , <b>and that death occurred at</b> <u>4:30 P.M.</u> <b>from the causes and on the date stated above.</b>   |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Sam E. Feary</u>  |  | <b>22b. DATE SIGNED</b><br><u>7/5/67</u>  |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Feary, Md.</u>   |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>JULY 7-1967</u>  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Louisa Park Cem.</u> |  | <b>23d. LOCATION</b> (City, town or county) <u>Baltimore</u> (State) <u>Md</u> |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Walters Funeral Home</u>  |  |   | <b>ADDRESS</b><br><u>Balto., Md.</u>                                 |  | <b>25a. REC'D BY REGISTRAR</b><br><u>JUL 12 1967</u>                           |   |  |
|   |  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>            |  | <b>DATE</b><br><u>JUL 12 1967</u>  |   |  |

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## CERTIFICATE OF DEATH

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|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Wisconsin</b> b. COUNTY <b>Kenosha</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   | c. LENGTH OF STAY IN lb<br><b>2 wks.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1811 Leadburne Rd. 21204</b>  |   | d. STREET ADDRESS<br><b>1814-75th. St.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Charles A. Kopecki</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>13</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>Cauc.</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-11-1892</b>  |
| 9. AGE (In years last birthday) yrs. <b>74</b>   |   | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (Country & State, or foreign country)<br><b>Czechoslovakia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Abton</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Novack</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>390 03 5408</b>   |  |
| 17. INFORMANT<br><b>Kopro</b>  |   | Address<br><b>Richard Kopecki, 1811 Leadburne Rd. 21204</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO <b>Pleural Effusion</b><br>DUE TO <b>Myocardial Degeneration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>5 Days</b><br><b>2 hrs</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/12/1967</b> to <b>2/13/1967</b> , that (I) (we) last saw the deceased alive on <b>2/12/1967</b> , and that death occurred at <b>3A</b> M, from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><b>Charles T. O'Donnell</b>  |   | 22b. DATE SIGNED<br><b>7/13/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles T. O'Donnell</b>  |   | 22d. ADDRESS<br><b>Towson, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7-15-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Georges</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Kenosha, Wisconsin</b>         |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 14 1967</b>  |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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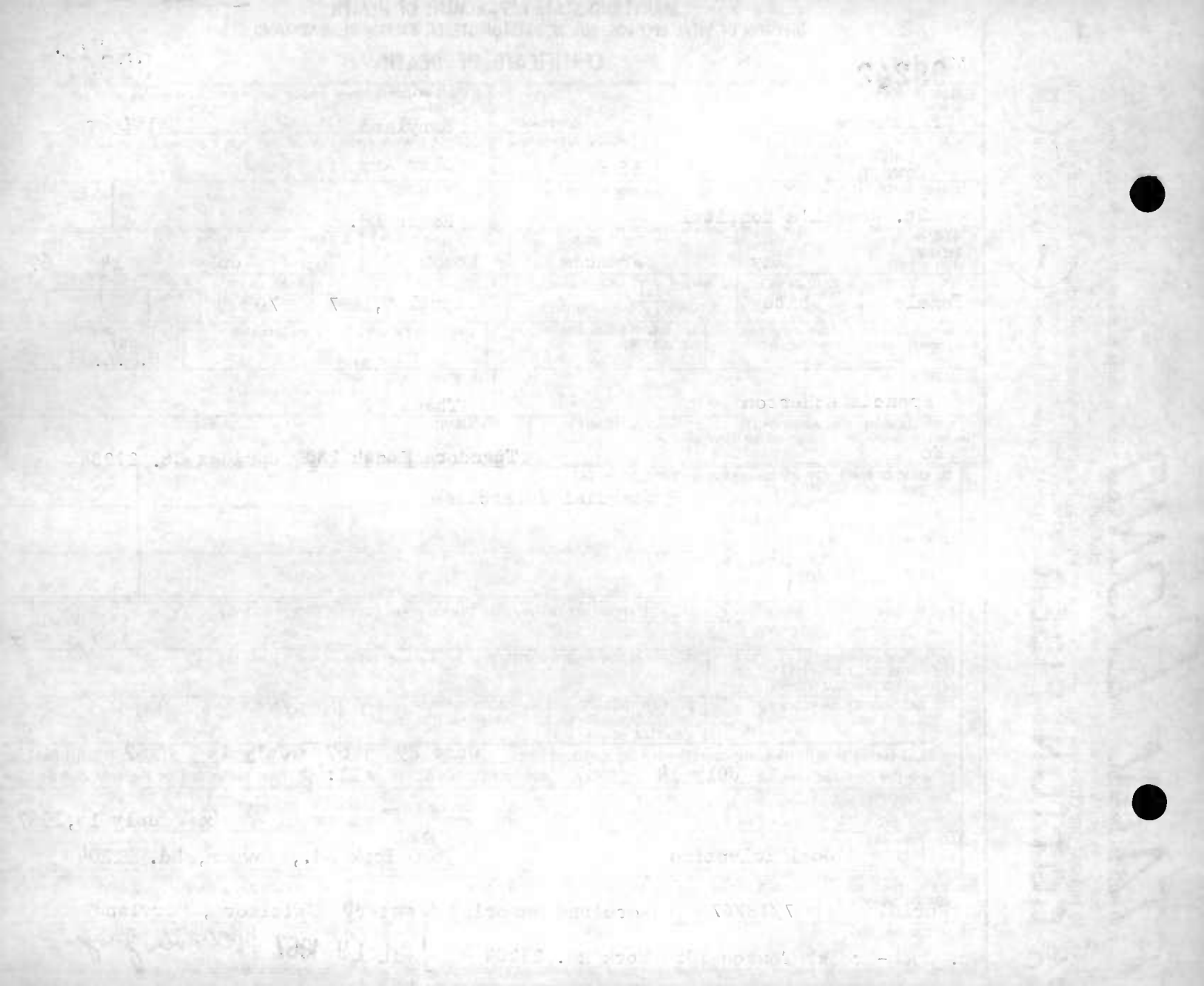
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>15 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b> |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Arm</b><br>d. STREET ADDRESS<br><b>Manor Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Amy</b><br>Middle<br><b>Frances</b><br>Last<br><b>Kozak</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>July</b><br>Day<br><b>14</b><br>Year<br><b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>April 8, 1897</b><br>9. AGE (In years<br>low 100s<br>10s<br>yrs.)<br><b>70</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired)<br><b>homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>England</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Francis Etherton</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Theda ?</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Theodore Kozak 2803 Upridge Ct. 21234</b>   |   |
| 17. INFORMANT<br><b>Theodore Kozak 2803 Upridge Ct. 21234</b>  |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 29, 1967</b> , to <b>July 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1967</b> , and that death occurred at <b>11:40 PM</b> from causes on and on the date stated above.                                       |                                  |   |   |
| 22a. SIGNATURE<br><b>Joel V. Tolentino</b>   |                                  | 22b. DATE SIGNED<br><b>July 14, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Joel Tolentino</b>  |                                  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/18/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 19 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Charles Judge</b>  |                                  |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

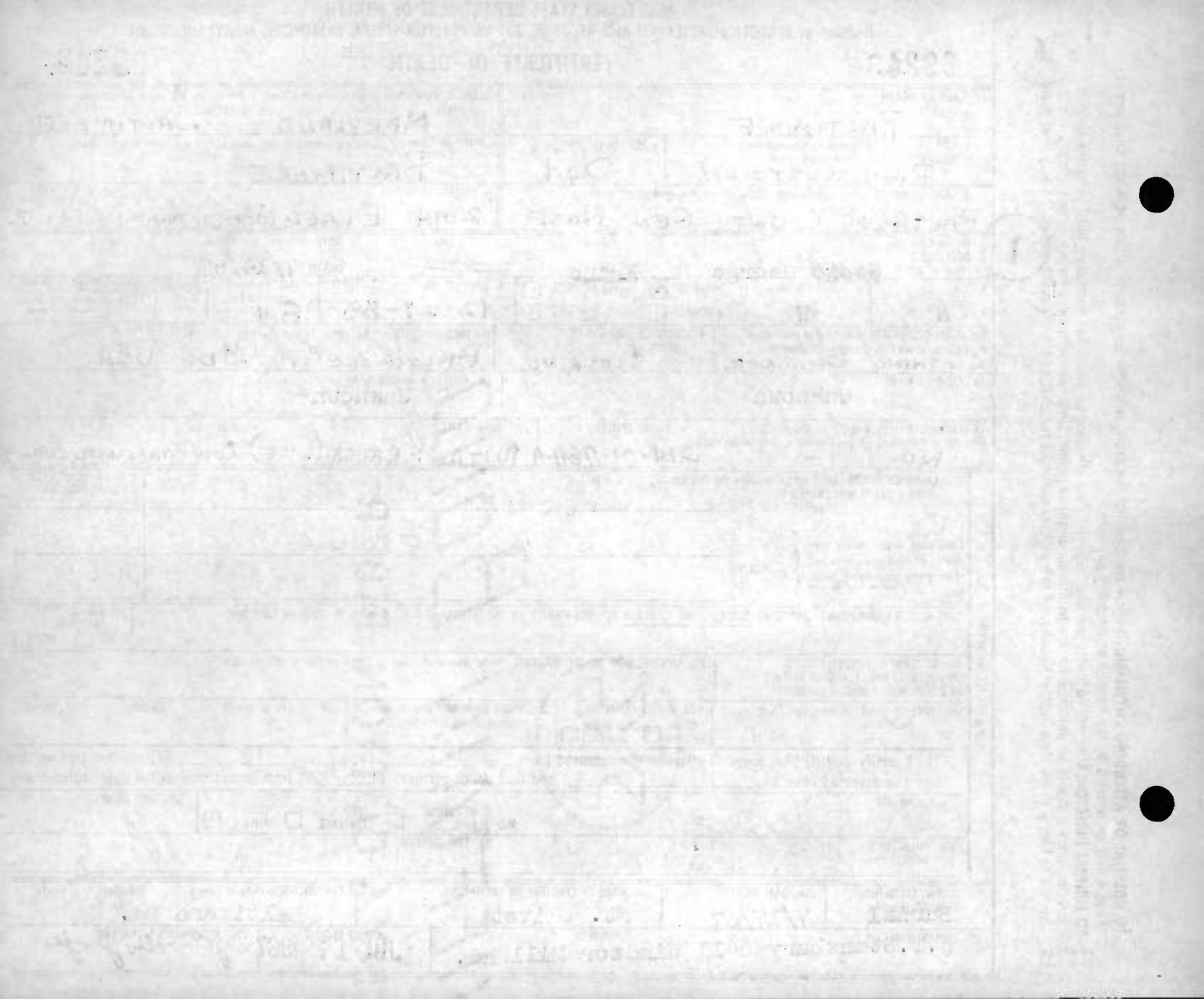
VR A15 (4)  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G390 7/20/67, kk

# CERTIFICATE OF DEATH

|  |  |  |   |
|--|--|--|---|
| 09243  |  | 09243  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RANDALLSTOWN</b>  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>BALTIMORE COUNTY GEN HOSP.</b>  |  | d. STREET ADDRESS<br><b>2014 ENGEL WOOD AVE</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>George Kraus</b>   |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>14</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>WW</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1882-27-85</b>                                 |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE CITY, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-01-7811-A</b>  |   |
| 17. INFORMANT<br><b>NITA KRAUS (WIFE)</b>  |  | Address<br><b>2014 ENGEL WOOD, BALTIMORE</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 Acute myocardial infarction</b><br>DUE TO (b) <b>generalized atherosclerosis</b><br>DUE TO (c) <b>—</b>   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>—</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>60</b> , to <b>7/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/8</b> , 19 <b>67</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>Milton Schlewoff</b>  |  | 22b. DATE SIGNED<br><b>7/15/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Milton Schlewoff M.D.</b>   |  | 22d. ADDRESS<br><b>6410 Windsor Mill Rd -7-</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/17/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>J.I. Stansbury</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 17 1967</b>  |   |
| ADDRESS<br><b>6411 Windsor Mill Rd.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09244

## CERTIFICATE OF DEATH

09243

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                 |   |  |  |   |   |  |
|---|---------------------------------|---|--|--|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                 |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Colorado</u> b. COUNTY <u>44-3</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore, 21234</u>   |                                 |   | c. LENGTH OF STAY IN 1b<br><u>2 mo.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Denver</u> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>8809 Littlewood, Rd.</u>   |                                 |   |  | d. STREET ADDRESS<br><u>13737 W. Virginia #44 Dr.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>Julia Kerr Lambright</u>  |                                 |   |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>July 2, 1967</u> 19  |   |   |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>Nov. 11, 1896</u> |  | 9. AGE (In years last birthday)<br><u>70</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pittsburgh, Pa.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Walter Kerr</u>   |                                 |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Julia Gass</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)<br><u>No.</u>   |                                 | 16. SOCIAL SECURITY NO.<br><u>302 32 9203</u>   |  | 17. INFORMANT Address<br><u>Dorothea Izant, 8809 Littlewood Rd.</u>  |   |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion - Instant</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Hypertensive arteriosclerotic cardiovascular disease</u><br>DUE TO<br>(c) |                                 |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Pneumonitis - right</u>  |                                 |   |  |  |   | 19. WAS AUTOPSY PERFORMED? #<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>July 2</u> , 19 <u>67</u> , that (I) <del>we</del> saw the deceased alive on <u>June 25</u> 19 <u>67</u> , and that death occurred at <u>1 a.</u> M, from causes and on the date stated above.  |                                 |   |  |  |   |   |  |
| 22a. SIGNATURE<br><u>W. H. Townshend</u> M.D.   |                                 |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                |   | 22b. DATE SIGNED<br><u>7-3-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>W. H. Townshend, Jr. M.D.</u>   |                                 |   |  | 22d. ADDRESS<br><u>14 E. Eager St. - Balto. Md.</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                 | 23b. DATE THEREOF<br><u>July 6, 67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Beaver Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Beaver, Pa.</u>                                 |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Wm. Cook-Brooks Towson, Towson, Md.</u>  |                                 |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 6 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

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## CERTIFICATE OF DEATH

09245

09244

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Balto.</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>   |  | c. LENGTH OF STAY IN 1b<br><b>16 MONTHS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Balto.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b> |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Dulaney-Towson Nursing Home</b>   |  |  |  | d. STREET ADDRESS<br><b>1401 MIDMEADOW RD.</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mary</b>  |  | First Middle Last<br><b>Layman</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 22 1967</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>April 30, 1881</b>   |  |
| 9. AGE (In years lost birthday)<br><b>86</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Robert Harvey</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Gibson</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>216-46-2830</b>  |  | 17. INFORMANT<br><b>MRS. MARY NORRIS, TOWSON, MD. 21204</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA</b><br>DUE TO (b) <b>CARCINOMA-COLON</b><br>DUE TO (c) <b>A.S.C.V. DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b><br><b>2 YEARS</b>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <del>this hospital</del> attended the deceased from <b>JAN.</b> , 19 <b>66</b> , to <b>JULY 23, 1967</b> , that (I) <del>we</del> saw the deceased alive on <b>JULY 23, 1967</b> , and that death occurred at <b>7:10 P.M.</b> from causes and on the date stated above.  |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Arthur Kargin</b>   |  |  |  | 22b. DATE SIGNED<br><b>JULY 23, 1967</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>ARTHUR KARGIN M.D.</b>   |  |
| 22d. ADDRESS<br><b>1532 HAVENWOOD ROAD.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>JULY 24, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FBG. MEMORIAL PARK</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG, MD.</b>                            |  |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, SR., FROSTBURG, MD. 21532</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 26 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Jones</b>   |  |

250



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                     |  |   |  |  |   |   |  |
|---|--|-------------------------------------|--|---|--|--|---|---|--|
| CERTIFICATE OF DEATH  |  |                                     |  |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                     |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  |                                     |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Armocost Nursing Home 812 Regester Ave</b>   |  |                                     |  |   | d. STREET ADDRESS<br><b>18 Dowling Circle Zone 18</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Otto</b>  |  |                                     | First Middle Last<br><b>Lengerhuis Sr.</b> |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>1967</b>                                 |   |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 8, 1902</b>   |   | 9. AGE (In years last birthday) <b>65</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min.          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Shop superintendant</b>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Machine Shop</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Germany</b>                                |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Gerhard Lengerhuis</b>  |  |                                     |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Peterke Voermann</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>216 05 2885</b>   |  | 17. INFORMANT<br><b>Mrs Philiptine Lengerhuis Balto Md 21234</b>                                     |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral metastases</b><br><b>163X</b> DUE TO <b>Carcinoma of lung.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerotic cardiovascular disease</b> |  |                                     |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                     |  |   |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8-20, 1960</b> to <b>7-10, 1967</b> , that (I) (we) last saw the deceased alive on <b>7-9, 1967</b> , and that death occurred at <b>11:5</b> A.M. from the causes and on the date stated above.  |  |                                     |  |   |  |  |   |   |  |
| 22a. SIGNATURE<br><b>Alfred M Ossman</b>  |  |                                     |  | 22b. DATE SIGNED<br><b>7-11-67</b>  |  |  |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Alfred Ossman</b>  |  |                                     |  | 22d. ADDRESS<br><b>1101 St Paul St.</b>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>7/13/67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Woodlawn Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers</b>   |  |                                     |  | ADDRESS<br><b>8728 Liberty Rd Randallstown Md</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 14 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

MEMORANDUM FOR THE DIRECTOR

Subject: [Illegible]

Reference: [Illegible]

Date: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09247

CERTIFICATE OF DEATH

09246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |   |  |  |                                  |
|---|----------------------------------|---|--|---|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> |  |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex</b>  |                                  |   | c. LENGTH OF STAY IN lb                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex</b> |  |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>314 Ida Ave. Balto., 21221, Md.</b>  |                                  |   |  | d. STREET ADDRESS<br><b>314 Ida Ave., Balto., 21221, Md.</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FRANKLIN</b> Middle <b>HARRY</b> Last <b>LEONARD</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>22</b> , 19 <b>67</b> .  |  |  |                                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Sept. 5, 1890</b> |   | 9. AGE (In years last birthday) yrs.<br><b>76</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Monumental Life</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |
| 13. FATHER'S NAME<br><b>Nicholas Leonard</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Theresa Peringer</b>   |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213-09-4095</b>   |  | 17. INFORMANT Address<br><b>Andrew H. Leonard : 314 Ida Ave. Balto., 21,</b>  |  |  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertension - cerebral - vascular</b><br>DUE TO <b>chronic - cerebral degeneration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) DUE TO |                                  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |   |  |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan - 1962</b> to <b>7/22, 1967</b> , that (I) (we) last saw the deceased alive on <b>7/20, 1967</b> , and that death occurred at <b>8:00</b> M. from causes on and on the date stated above.  |                                  |   |  |   |  |  |                                  |
| 22a. SIGNATURE<br><b>Joseph R. Liberto</b>  |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><b>7/25/67</b>   |                                  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Joseph R. Liberto</b>  |                                  |   |  | 22d. ADDRESS<br><b>3508 Bank St., Balto., 21224, Md.</b>  |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7-26-67.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>4430 Belair Rd., Balto., Md.</b>           |                                  |
| 24. FUNERAL DIRECTOR<br><b>Charles J. Zeiler</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 27 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |

6480

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09248

CERTIFICATE OF DEATH

09247

|  |  |   |                                      |
|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>                  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie 21061</b>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>GREATER BALTO. MEDICAL CENTER.</b>  |  | d. STREET ADDRESS<br><b>Hamilton Place</b>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print) <b>BABY GIRL LINSENMAYER</b>  |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>27</b> Year <b>1967</b>   |                                      |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-27-67</b>   |
| 9. AGE (In years lost birthday) yrs.<br><b>2</b>   |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>48</b>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N.A.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N.A.</b>  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTO. MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                      |
| 13. FATHER'S NAME<br><b>GLENN ROSS LINSENMAYER</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANN LOUISE SCHMIDT</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>N.A.</b>  |                                      |
| 17. INFORMANT<br><b>CHART</b>  |  | Address   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>776X</b> IMMEDIATE CAUSE (a) <b>Extremely premature with 284 gm weight</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/27, 1967</b> , to <b>7/27, 1967</b> that (I) (we) last saw the deceased alive on <b>7/27, 1967</b> , and that death occurred at <b>5:01 A.M.</b> , from causes and on the date stated above.  |  |   |                                      |
| 22a. SIGNATURE<br><b>Alan A. Dammick</b>   |  | 22b. DATE SIGNED<br><b>7/27/67</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF   |                                      |
| <b>Cremation</b>   |  | <b>Aug. 1, 1967</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chase</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Towson Md. 21204</b>  |                                      |
| 24. FUNERAL DIRECTOR<br><b>John E. Adams, M.D.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE AUG 4 1967</b>   |                                      |
| ADDRESS<br><b>Chase</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                      |

7-254347

6220

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 0390 7/21/67 Jc

09249

CERTIFICATE OF DEATH

09248

|   |                               |  |                                      |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Baltimore</b>               |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                               | c. LENGTH OF STAY IN 1b  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Bloomsbury Retreat</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville Baltimore #29</b>   |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Walter G. Linthicum</b>  |                               | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>12</b> Year <b>19 67</b>  |                                      |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>Wh</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Mar. 4/83</b> |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   |                               | IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |
| 13. FATHER'S NAME<br><b>George W. Linthicum</b>   |                               | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Whitaker</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.<br><b>216-05-8569</b>  |                                      |
| 17. INFORMANT<br><b>Heleen L. Carter</b><br><b>954 Andrews Rd. - West Palm Beach, Fla.</b>  |                               | Address  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/13</b> , 19 <b>67</b> to <b>7/12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> , 19 <b>67</b> , and that death occurred at <b>7:00</b> M, from causes and on the date stated above.                                      |                               |  |                                      |
| 22a. SIGNATURE<br><b>Paul R. Ziegler</b>  |                               | 22b. DATE SIGNED<br><b>7/13/67</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul J. Ziegler, M. D.</b>   |                               | 22d. ADDRESS<br><b>200 WESTNOT HILL DR ELLICOTT CITY MD</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 23b. DATE THEREOF<br><b>7/15/67</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>  |                               | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |                                      |
| 24. FUNERAL DIRECTOR<br><b>Witzke F. D. - 4101 Edmondson Ave.</b>   |                               | 25a. REC'D BY REGISTRAR<br><b>DATE 'UL 14 1967</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                               |  |                                      |

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U. M. Tolstoy, *Don*

Item 2 Film 3301 8/21/67

09248

09250

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b><br>c. LENGTH OF STAY IN 1b<br><b>30 4</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville 903-2A Nottingham Rd.</b><br>d. STREET ADDRESS<br><b>Summitt Nursing Home 98 Smithwood Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Susan Frances Loechel</b><br>First Middle Last  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 19 19 67</b>   |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>Cauc.</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Mar. 27/89</b>                                  |
| 9. AGE (In years last birthday)<br><b>78 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Benjamin Beck</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mr. Philip Loechel 110 Donleigh Dr. - 21150</b><br>Address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vasc. Accident</b><br>DUE TO<br>(b) <b>Hypertensive C.V.D.</b><br>DUE TO<br>(c) <b>Deterioration of Bladder &amp; Kidney</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Generalized Arteriosclerosis</b>  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 hrs</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 19 67</b> to <b>July 19 67</b> that (I) (we) last saw the deceased alive on <b>July 19 67</b> and that death occurred at <b>7:19 PM</b> from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><b>Dr. Thomas G. Abbott</b><br>M.D.  |  | 22b. DATE SIGNED<br><b>July 19 67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Thomas Abbott</b>   |  | 22d. ADDRESS<br><b>4509 Liberty Heights Ave.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/21/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Witzke F. D. - 4101 Edmondson Ave.</b><br>ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 20 1967</b>   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09251

CERTIFICATE OF DEATH

09250

|  |                                  |   |  |  |   |  |   |
|--|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON -4</b>   |                                  | c. LENGTH OF STAY IN Ib<br><b>38 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>21214</b>                       |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |                                  |   |  | d. STREET ADDRESS<br><b>5510 P. 19th ROAD</b>  |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>FRANK William Loeschke</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 12 1967</b>  |   |  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-24-93</b>                                     |  | 9. AGE (In years last birthday)<br><b>73</b> yrs. | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                      |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED Office Mgr. Distillery</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTIMORE, Md.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                         |   |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Not</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>215-10-6749</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Charlotte Loeschke (Same)</b>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1810 IMMEDIATE CAUSE (a) CANCER of BLADDER</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |                                  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Blood Pressure drop</b>  |                                  |   |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)              |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6/14</b> , 1967, to <b>7/11</b> , 1967, that (I) (we) last saw the deceased alive on <b>7/12</b> , 1967, and that death occurred at <b>3:50 A.M.</b> , from causes and on the date stated above.                          |                                  |   |  |  |   |  |   |
| 22a. SIGNATURE<br><b>N. Eftekhari</b>  |                                  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>7/12/67</b>                                 |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. N. Eftekhari</b>  |                                  |   |  | 22d. ADDRESS<br><b>G.B.M.C. N. Charles St. Baltimore Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/15/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 12 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>        |   |

1-22-51

Baltimore

Unknown

38 days Baltimore 21216

Center Baltimore Medical Center 3210 Phipps Road

Male White Frank X William Jacobs July 12 52  
9-24-53 12

Retired U.S. Army Baltimore, Md.  
Unknown

212-10-1744 Baltimore, Md.

CANCER of BLADDER

Blood Pressure Drop

3-20-54 2114 2111 21

7-11-52

Dr. N. E. Egan  
689-C N. Broadway - Baltimore, Md.  
X 11/11/51



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09252

CERTIFICATE OF DEATH

09251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |   | c. LENGTH OF STAY IN 1b<br><b>46 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SAMUEL</b> Middle <b>- - -</b> Last <b>LOGAN</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>4</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/1/96</b>                                |
| 9. AGE (In years lost birthday) yrs.<br><b>71</b>  |   | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>14</b> Hours <b>05</b> Min. <b>00</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Sumter, S.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Samuel Logan</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Jane</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW-1</b>   |   | 16. SOCIAL SECURITY NO.<br><b>220 09 95 14</b>  |  |
| 17. INFORMANT<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERALLY, UNDETERMINED ORGANISM</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.<br>(b) <b>BONE METASTASES</b><br>(c) <b>ADENOCARCINOMA OF PROSTATE</b> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ARTHRITIS LEFT KNEE, UNDETERMINED ETIOLOGY</b>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                             |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 19 19 67</b> , to <b>July 4, 19 67</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>July 4 19 67</b> , and that death occurred at <b>9:05 M.</b> from causes and on the date stated above.                           |   |   |  |
| 22a. SIGNATURE<br><b>Wilton Neilson</b>  |   | 22b. DATE SIGNED<br><b>7/5/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILON NEILSON, M. D.</b>   |   | 22d. ADDRESS<br><b>VA Hospital, Fort Howard, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>7-10-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO MD</b> |
| 24. FUNERAL DIRECTOR<br><b>Marshall P. Hayes</b>   |   | 25. REGISTRATION<br><b>667</b>  |  |
| 26. SIGNATURE<br><b>Marshall P. Hayes</b>  |   |   |  |

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09253

09253

|   |                              |   |  |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>  |                              | c. LENGTH OF STAY IN <u>8 days</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u> 75-3 17112   |                              | d. STREET ADDRESS <u>7186 Jonestown Rd.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>  |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Burt</u> Middle <u>Price</u> Last <u>Long</u>  |                              | 4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1967</u>  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>Can.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-13-94</u> 72 yrs. 72 <sup>1st</sup> birthday |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                              | 11. BIRTHPLACE (County & State, or foreign country) <u>Hannibal, Mo.</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                              | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Miles G. Long</u>  |                              | 14. MOTHER'S MAIDEN NAME <u>Sara A. Wingard</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1917-1917</u>   |                              | 16. SOCIAL SECURITY NO. <u>172-01-3883</u>  |  |
| 17. INFORMANT <u>Chart</u>  |                              | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u><br>DUE TO (b) <u>Diastolic heart disease</u><br>DUE TO (c) <u>Atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>16 hrs</u><br><u>80 years</u><br><u>25 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Operation for resection of abdominal aortic aneurysm 7.5.67</u>  |                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 7</u> , 19 <u>67</u> , to <u>July 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 10</u> , 19 <u>67</u> , and that death occurred at <u>2:01 AM</u> , from causes and on the date stated above.  |                              |   |  |
| 22a. SIGNATURE <u>Tom Poliness M.D.</u>   |                              | 22b. DATE SIGNED <u>July 10 '67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>TOM POLINESS</u>  |                              | 22d. ADDRESS <u>% CBMC, 6701 N. CHARLES ST., BALTIMORE MD</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                              | 23b. DATE THEREOF <u>7/12/67</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>BLUE RIDGE MEMO</u>   |                              | 23d. LOCATION (City or Town) (County) (State) <u>HARRISBURG PA</u>  |  |
| 24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u>  |                              | 25a. REC'D BY REGISTRAR <u>JUL 17 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>FOR ZIMMERMAN FUNERAL HOME</u>  |                              |   |  |

00525

DEPARTMENT OF THE ARMY

Topographic

Geographical

California

Townson

8 days

18 days

Greater Salt Lake County

1st Longhorn Rd.

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1st

2

Gen

1-15-14

Thurmond, Mo.

Wiles & Land

Seco A. Ringford

Chart

101-101-101-101-101

yes

A. C. H.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09258

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>5 Ritters Lane</u>  |                                  | d. STREET ADDRESS<br><u>5 Ritters Lane</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Albert</u> Last <u>Long Jr.</u>  |                                  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>11</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>February 10, 1905</u> |
| 9. AGE (In years last birthday)<br><u>62</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Employed State Roads</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13. FATHER'S NAME<br><u>Charles A. Long Sr.</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Laura E. Hanson</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>212-20-0577</u>   |  |
| 17. INFORMANT<br><u>Mrs. Mary M. Long, Owings Mills, Md.</u>   |                                  | Address<br><u>  </u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO (b) <u>Myocarditis - decompensating</u><br>DUE TO (c) <u>Drugs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>few years</u> |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>  </u>  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  |
| 20c. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                  | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |  |
| 20e. (City or town)<br><u>  </u>   |                                  | 20f. (County) (State)<br><u>  </u>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-1-40</u> , 19 <u>  </u> , to <u>7-11-67</u> , that (I) <u>we</u> last saw the deceased alive on <u>7-11-67</u> , 19 <u>67</u> , and that death occurred at <u>11A</u> M, from causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><u>James G. Siffell</u>  |                                  | 22b. DATE SIGNED<br><u>7-12-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>James G. Siffell</u>  |                                  | 22d. ADDRESS<br><u>Reisterstown, Balto Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>July 14, 1967</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>David Ridge</u>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Pikesville, Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>  |                                  | 25. REC'D BY REGISTRAR<br>DATE <u>JUL 13 1967</u>   |  |
| 26. REGISTRAR'S SIGNATURE<br><u>Charles J. Jager</u>   |                                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09255

CERTIFICATE OF DEATH

09254

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>15 Days</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21228 03-1</b>  |                                  | d. STREET ADDRESS<br><b>6501 Frederick Road</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>PAUL CHARLES LORENZ</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>15</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>11/19/92 57 7/4</b> |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Printer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Rhinehart Lorenz</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Fisher</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>215-08-88-56</b>  |  |
| 17. INFORMANT<br><b>Clin. Rec. VAH, Fort Howard, Maryland</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>154X</b><br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA RECTO SIGMOID</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>DIABETES MELLITUS</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 30</b> , 19 <b>67</b> , to <b>July 15</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 15</b> , 19 <b>67</b> , and that death occurred <b>12:15AM</b> from causes and on the date stated above. |                                  |   |  |
| 22a. SIGNATURE<br><b>Jorge A. Fabara</b>   |                                  | 22b. DATE SIGNED<br><b>7/15/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JORGE A. FABARA, M.D.</b>   |                                  | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/18/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>McNabb Funeral Home</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 19 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |  |

06255

Bellevue

Fort Howard

15 Days

Bellevue

Bellevue

Bellevue

YACHT

YACHT

YACHT

Male

X

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Yes

X

Bellevue

Bellevue

YACHT

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

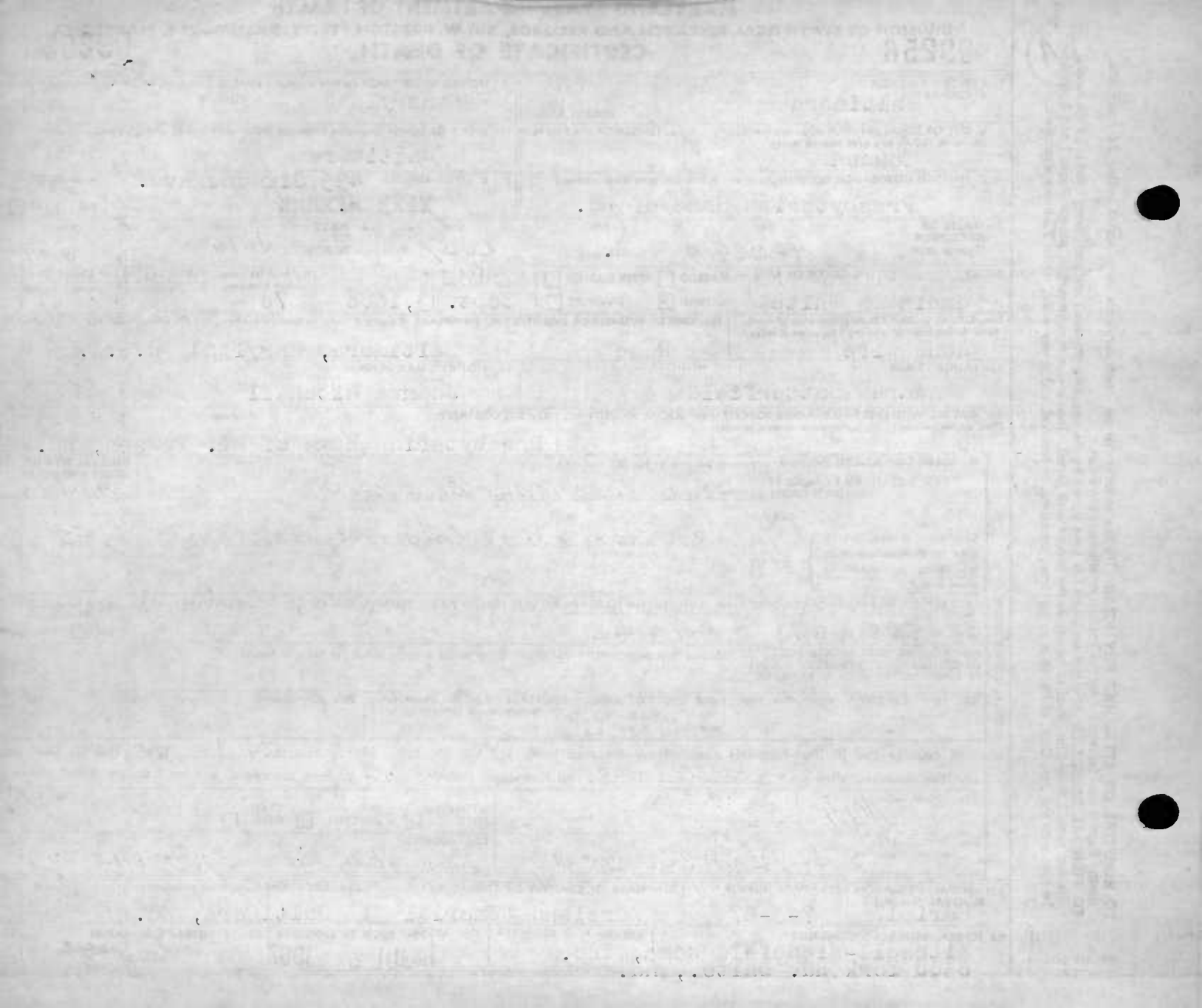
Bellevue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 5-63

MEDICAL CERTIFICATION

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |   |  |   |  |  |   |   |  |
|--|--|--|---|---|--|---|--|--|---|---|--|
| 09256 CERTIFICATE OF DEATH 09255   |  |  |   |   |  |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b><br>c. LENGTH OF STAY IN b. <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Presbyterian Home of Md.</b>   |  |  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>BALTO.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>435 Simmons Ave.</b><br><b>XXXXXX XXXXX</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Georgia E. LUBY</b>  |  |  | 4. DATE OF DEATH <b>July 1, 1967</b>          |   |  | 5. SEX <b>Female</b>  |  |  | 6. COLOR OR RACE <b>White</b>                             |   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH <b>Sept. 3, 1888</b>         |   |  | 9. AGE (In years last birthday) <b>78</b> yrs.  |  |  | 10. IF UNDER 1 YEAR Months Days                           |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b> |   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                |   |  |
| 13. FATHER'S NAME <b>Andrew Satterfield</b>  |  |  |   |   |  | 14. MOTHER'S MAIDEN NAME <b>Joanna Mitchell</b>   |  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |  |   |   |  | 16. SOCIAL SECURITY NO. <b>Presbyterian Home of Md. Towson, Md.</b>   |  |  |   |   |  |
| 17. INFORMANT <b>Presbyterian Home of Md. Towson, Md.</b>  |  |  |   |   |  |   |  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4201</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Dis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PERNICIOUS ANEMIA</b> |  |  |   |   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b><br><b>YES</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |   |  |   |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |  |   |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)                          |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1960</b> to <b>July 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 28, 1967</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.   |  |  |   |   |  |   |  |  |   |   |  |
| 22a. SIGNATURE <b>S. J. VENABLE JR M.D.</b>  |  |  |   |   |  | 22b. DATE SIGNED  |  |  | 22c. PHYSICIAN'S NAME (Type) <b>S. J. VENABLE JR M.D.</b> |   |  |
| 22d. ADDRESS <b>7215 York Rd. BALTIMORE MD</b>   |  |  |   |   |  | 22e. REC'D BY REGISTRAR <b>JUL 5 1967</b>   |  |  | 22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |   | 23b. DATE THEREOF <b>7-5-67</b>             |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>            |   |   |  |
| 23d. LOCATION (City, town or county) <b>Baltimore, Md.</b>   |  |  |   | 23e. LOCATION (State) <b>Baltimore, Md.</b> |  |   |  | 23f. LOCATION (Country) <b>Baltimore, Md.</b>                          |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Mitchell-Wiedefeld Home, Inc.</b><br><b>6500 York Rd. Balto., Md.</b>  |  |  |   |   |  |   |  |  |   |   |  |



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09257

CERTIFICATE OF DEATH

09256

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  | c. LENGTH OF STAY IN lb<br><b>49 DAYS</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |  | d. STREET ADDRESS<br><b>1738 E. LANSVILLE STREET</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>AMOS CORNELIUS LUCAS</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 19, 19 67</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/22/14</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>53</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TRUCK DRIVER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>RICHMOND, VIRGINIA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>AMOS R. LUCAS</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>MAGGIE WASHINGTON</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWII</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212 16 01 33</b>  |   |
| 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>HEPATIC METASIS</b><br>(c) <b>PULMONARY TUMOR, UNSPECIFIED TYPE, LEFT LUNG</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b><br><b>UNKNOWN</b><br><b>UNKNOWN</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CHRONIC ALCOHOLISM; RHEUMATIC HEART DISEASE, MITRAL INSUFFICIENCY</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>6 5/31/67</b> , 19__, to <b>7/19/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>7/19/67</b> , 19__, and that death occurred at <b>11:45 PM</b> from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><i>Neilson Neilson</i>   |  | 22b. DATE SIGNED<br><b>7/20/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILSON NEILSON, M. D.</b>  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>7/26/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>ELLIOT FUNERAL HOME</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 24 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |   |   |

5258

2002

1455

2.

ALREADY, COMMENTS

• 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652,

STRAIN CYTAS

8-10

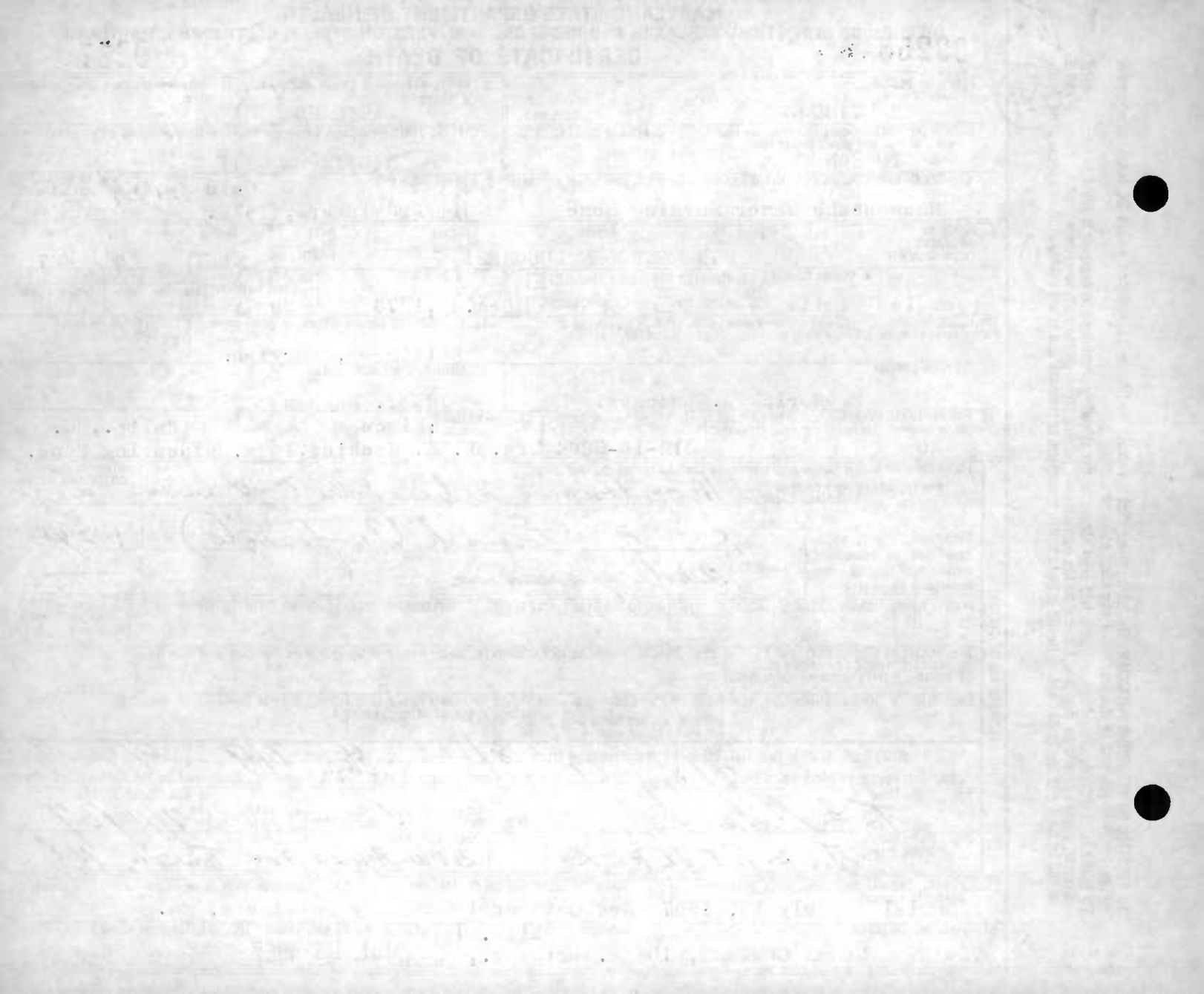


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |  |  |   |   |  |  |
|--|--|---|--|---|--|--|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |  |  |   |   |  |  |
| 09258 CERTIFICATE OF DEATH 09257   |  |   |  |   |  |  |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> |  |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>  |  |   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE CITY</b>                                    |  |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Chesapeake Manor Nursing Home</b>   |  |   |  |   |  | d. STREET ADDRESS<br><b>Cold Spring Guilford Towers, 14 W.</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>JOSEPHINE SNOWDEN LUCCHESI</b>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 9 1967</b>   |  |   |   |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Dec. 22, 1876</b>   |  | 9. AGE (In years last birthday)<br><b>90</b> yrs. |   | IF UNDER 1 YEAR<br>Months Days Hours Min.                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 13. FATHER'S NAME<br><b>Frederick A. Lucchesi</b>  |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida I. Masson</b>   |  |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-10-3294</b> |  | 17. INFORMANT<br><b>Niece</b>   |  | Address <b>Balto., Md.</b>   |  |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Arterio Scler. C-V disease</b><br><b>H43X</b><br>DUE TO (b) <b>C. A. Stomach (Inoperable)</b><br>DUE TO (c) <b>2 ndary anemia</b>                 |  |   |  |   |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>1 1/2 yrs.</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |   |  |  |  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)              |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/22</b> , 19 <b>66</b> , to <b>7/19</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/18</b> , 19 <b>67</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. |  |   |  |   |  |  |  |   |   |  |  |
| 22a. SIGNATURE<br><b>T. A. Sedlack</b>   |  |   |  |   |  | 22b. DATE SIGNED<br><b>7/10/67</b>   |  |   |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>T. A. SEDLACK</b>   |  |   |  |   |  | 22d. ADDRESS<br><b>200 W. Pennek Ave. Towson, Md</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>July 12, 1967</b>     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery Baltimore, Md.</b>  |  |  |  | 23d. LOCATION (City, town or county) (State)      |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>STEWART &amp; MOWEN COMPANY, 108 W. North Av.,</b>  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1967</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Young</b>   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                 |  |   |  |   |  |  |                                  |
|---|--|---------------------------------|--|---|--|---|--|--|----------------------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                 |  |   |  |   |  |  |                                  |
| CERTIFICATE OF DEATH  |  |                                 |  |   |  |   |  |  |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shady Nook Nursing Home</b>  |  |                                 |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Balto</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>d. STREET ADDRESS <b>29 Cedar Hill Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Lucke</b> Last <b>Lucke</b>   |  |                                 |  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>3</b> Year <b>1967</b>  |   |  |  |                                  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan 3, 1883</b>  |  | 9. AGE (In years last birthday) <b>84</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  |                                 |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Balto, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                  |
| 13. FATHER'S NAME <b>Roderick McInnis</b>   |  |                                 |  |   | 14. MOTHER'S MAIDEN NAME <b>Neta ( unknown)</b>  |   |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)   |  |                                 |  | 16. SOCIAL SECURITY NO. <b>none</b>   |  | 17. INFORMANT Address <b>Mr. Frank Lucke 29 Cedar Hill Road</b>   |  |  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>4201<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MASCVN</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) |  |                                 |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                 |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                 |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.   |  |                                 |  |   |  |   |  |  |                                  |
| 22a. SIGNATURE <b>Eugenio E. Benitez M.D.</b>   |  |                                 |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED <b>7/5/67</b>   |                                  |
| 22c. PHYSICIAN'S NAME (Type) <b>Eugenio E. Benitez M.D.</b>   |  |                                 |  |   |  | 22d. ADDRESS <b>3350 Wilkins Ave. Balto. Md.</b>  |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>   |  | 23b. DATE THEREOF <b>7/6/67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>  |  |   | 23d. LOCATION (City, town or county) (State) <b>Woodlawn Balto Co Md</b> |  |                                  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Spring Byers 8728 Liberty Rd Md</b>   |  |                                 |  |   |  | 25a. REC'D BY REGISTRAR <b>JUL 7 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Juan Carlos Young</b>  |                                  |

00000

Belmont

Unemployment

Shady Brook Farming House

Albany

Also

Honolulu

Kodakish Islands

Room

no

St. Frank Lincoln 19 Cedar Hill 1 Room

1-2-3, 1283

Haito, 14

Room 1 (unoccupied)

Locks

July 2

1961

Also

Cambridge

29 Cedar Hill Road

3350 Wilkins Ave. Hilo, HI

Honolulu, HI

Unemployment

Honolulu

Also 00

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VR A15 (4)  
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                   |  |   |  |  |  |   |  |
|--|--|-----------------------------------|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                   |  |   |  |  |  |   |  |
| 09260  |  |                                   |  |   | 09259  |  |  |   |  |
| 1. PLACE OF DEATH  |  |                                   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                  |  |  |   |  |
| a. COUNTY <b>Baltimore</b>   |  |                                   |  |   | a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  |                                   |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b> |  |  |   |  |
| c. LENGTH OF STAY IN ID<br><b>10 Years</b>   |  |                                   |  |   | d. STREET ADDRESS<br><b>6012 Moorehead Road</b>  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6012 Moorehead Road</b>   |  |                                   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)  |  |                                   |  |   | 4. DATE OF DEATH   |  |  |   |  |
| First <b>Rosina</b> Middle <b>M.</b> Last <b>Ludwig</b>  |  |                                   |  |   | Month <b>July</b> Day <b>28</b> Year <b>19 67</b>  |  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5/9/89</b>              |  | 9. AGE (In years last birthday)<br><b>78</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |  | IF UNDER 1 YEAR<br>Months Days Hours Min.         |  |
| 13. FATHER'S NAME<br><b>George Fassel</b>  |  |                                   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Virginia Kimball</b>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |                                   |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT (Daughter)<br><b>Mrs. Ida Wiessner, 6012 Moorehead Rd.</b> |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4201</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Coronary Artery Disease causing</b><br>DUE TO (c) <b>Complete Heart Block</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Seconds</b><br><b>Unbearable</b><br><b>months</b> |  |                                   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                   |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |                                   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                   |  |   |  |  |  |   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |                                   |  |   |  |  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                                   |  |   |  |  |  |   |  |
| 20f. (City or town) (County) (State)   |  |                                   |  |   |  |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 1962, to <b>7/28</b> , 1962, that (I) (we) last saw the deceased alive on <b>6/15</b> , 1962, and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.   |  |                                   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>James J. Nolan</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |                                   |  |   |  |  |  |   |  |
| 22b. DATE SIGNED <b>7/29/67</b>  |  |                                   |  |   |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>James J. Nolan</b> M. D. 22d. ADDRESS <b>1 Mallow Hill Rd. Catonsville, Md.</b>  |  |                                   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                                   |  |   |  |  |  |   |  |
| 23b. DATE THEREOF <b>7/31/67</b>   |  |                                   |  |   |  |  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>  |  |                                   |  |   |  |  |  |   |  |
| 23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>  |  |                                   |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |  |                                   |  |   |  |  |  |   |  |
| 25a. REC'D BY REGISTRAR <b>AUG 1 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |                                   |  |   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09261

CERTIFICATE OF DEATH

09260

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>5yr11mth26dys</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |  |  | d. STREET ADDRESS<br><b>72 Southgate Avenue</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <b>Caroline M. Lutz</b>   |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>19 67</b>   |  |   |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 21, 1896</b>  | 9. AGE (In years lost birthday)<br><b>71</b> yrs.                      | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>secretary</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>US Gov't</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |   |
| 13. FATHER'S NAME<br><b>J. August Lutz</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna M. Putzen</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><b>220-48-5350T</b>   |   | 17. INFORMANT<br>Address <b>Records: SPRING GROVE STATE HOSPITAL</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>193X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Generalized arteriosclerosis - Malnutrition</b>   |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |  |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 27, 19 61</b> to <b>July 23, 19 67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 23, 19 67</b> , and that death occurred at <b>6:35 AM</b> , from causes on and on the date stated above. |  |  |   |  |   |
| 22a. SIGNATURE<br><b>Stella Wachslor</b>   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                       |   | 22b. DATE SIGNED<br><b>7-23-67</b>                                     |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslor, M.D.</b>   |  | 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>July 27, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Annapolis A.A. Md.</b>  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Beverly E. Hopping</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Beverly E. Hopping</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                  |   |
| 24. FUNERAL HOME<br><b>Hopping Funeral Home - Annapolis, Md.</b>   |  | DATE <b>JUL 31 1967</b>  |   |  |   |

STATE OF TEXAS

1900

County of ...  
I, the undersigned, Clerk of the County of ...  
do hereby certify that ...  
Witness my hand and seal of office this ... day of ...  
1900.

Attest my hand and seal of office this ... day of ...  
1900.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09262

CERTIFICATE OF DEATH

09261

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore Co.</b><br>c. LENGTH OF STAY IN 1b<br><b>131</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore Co.</b><br>d. STREET ADDRESS<br><b>6721 Hillendale Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>James</b> Middle <b>Albert</b> Last <b>Maestri</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>15</b> Year <b>1967</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>2-13-28</b>  |  |
| 9. AGE (In years lost birthday)<br><b>39</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>15</b>  |  | IF UNDER 24 HRS.<br>Hours <b>15</b> Min. <b>00</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Program Representative</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>US Pub. Health</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Arkansas</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Leo Maestri</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Levezzi</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 9-25-46 1-28-48</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>432 34 9637</b>   |  | 17. INFORMANT<br>Address<br><b>Catherine D. Maestri</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) DUE TO<br>(c) DUE TO |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>instantaneous</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>July 15, 1967</b> , to <b>July 15, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>did not see</b> <del>1967</del> and that death occurred at <b>4:45 PM</b> , from causes and on the date stated above.      |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Worth Daniels, Jr.</b>   |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED<br><b>7/16/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Worth Daniels, Jr.</b>   |  |  |  | 22d. ADDRESS<br><b>11 E. Chase St.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE THEREOF<br><b>7-17-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Liberty Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Greenwood Arkansas</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. E. Johnson. 8521 Loch Raven Blvd. Balto. Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 19 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RANDALLSTOWN</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Woodmoor</u>   |   |
| c. LENGTH OF STAY IN lb<br><u>3 days</u>  |   | d. STREET ADDRESS<br><u>3523 Essex Rd. 21207</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Balto. Co. Gen. Hosp.</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Thomas</u> Middle <u>Clayton</u> Last <u>MAGEE</u>  |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>13</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-31-17</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Sales Rep.</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Frantz Mfg.</u>   | 9. AGE (In years last birthday)<br><u>49</u> yrs.                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ohio</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>?</u>  |   |
| 13. FATHER'S NAME<br><u>John MAGEE</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Emma Hops Tetter</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><u>234-10-4845</u>   | 17. INFORMANT<br><u>Hosp. Record</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL INFARCTION (CVA)</u><br>331X DUE TO (b) <u>Rt Internal Carotid Artery Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>ATHEROSCLEROSIS</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>67</u> , to <u>7-13</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7-13</u> , 19 <u>67</u> , and that death occurred at <u>10:50</u> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><u>Ralando A. Mphambe</u> M.D.  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED<br><u>7-13-67</u>  |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE THEREOF<br><u>7/14/1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Wm. F. Tidwell Sons North Ave. Balto., Md.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Clarksburg, West Virginia</u>   |
| 24. FUNERAL DIRECTOR<br><u>Wm. F. Tidwell Sons North Ave. Balto., Md.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 18 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09263

09262

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|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1203 Elmridge Ave. 21229</b>  |  | d. STREET ADDRESS<br><b>1203 Elmridge Ave. 21229</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Berniece A. Mahoney</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>July 5, 1916</b> |
| 9. AGE (In years last birthday)<br><b>51 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Westinghouse Air Arm. Div.</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Conn.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>- - - Wozniak</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Helen - - -</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>026-10-3349</b>  |   |
| 17. INFORMANT<br><b>Mr. Joseph P. Mahoney, 1203 Elmridge Ave.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Leiomysarcoma of the small intestine with metostasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>lyr.</b><br>(c) <b>lyr.</b> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>July 8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 8</b> , 19 <b>67</b> , and that death occurred at <b>3:25 P.M.</b> from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>Dr. Herbert J. Levickas</b>   |  | 22b. DATE SIGNED<br><b>7/10/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Herbert J. Levickas</b>   |  | 22d. ADDRESS<br><b>5404 East Drive</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/12/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |

CERTIFICATE OF DEATH

1917

Name of deceased

Age

Sex

Color

Date of death

Place of death

Signature of physician

Signature of registrar

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #G391 8/14/67 pn

09264

CERTIFICATE OF DEATH

09263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  | d. STREET ADDRESS<br><b>3401 Upton Road #21234</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Louis Maivelett Sr.</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>28</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 13, 1888</b>   |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>18</b> Hours <b>24</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chauffeur</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hendler's Ice Cream</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Italy</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>  |   |
| 13. FATHER'S NAME<br><b>Flaviano Maivelett</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>D'Egidio Abruzzi</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>215-03-2843</b>   |   |
| 17. INFORMANT (nee Izzo)<br><b>Antoinette Maivelett, wife, above</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage - right side</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour "a.m." _____ p.m. _____   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1967</b> , to <b>July 28, 1967</b> , that (I) (we) lost saw the deceased alive on <b>July 28, 1967</b> , and that death occurred at <b>3:00A</b> M, from causes on and the date stated above.                                |  |   |   |
| 22a. SIGNATURE<br><b>Elmo Gayoso</b>   |  | 22b. DATE SIGNED<br><b>7-28-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Elmo Gayoso, M.D.</b>   |  | 22d. ADDRESS<br><b>7620 York Road #21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/31/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>                               |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 1 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09265

09264

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>  |                                      | c. LENGTH OF STAY IN lb <b>8 days</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>   |                                      | d. STREET ADDRESS <b>3712 Liberty Hts. Avenue</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>CYPRIAN MALISZEWSKI</b>   |                                      | 4. DATE OF DEATH <b>July 5, 1967</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept 26 1893</b>   |
| 9. AGE (In years last birthday) <b>73</b> yrs.  |                                      | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Poland</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  |
| 13. FATHER'S NAME <b>Peter Malisewski</b>   |                                      | 14. MOTHER'S MAIDEN NAME <b>Catherine Piaseski</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                                      | 16. SOCIAL SECURITY NO. <b>216-07-9695</b>   |  |
| 17. INFORMANT <b>Melvin Pruchniewski</b>  |                                      | Address <b>313 Twin Oak Rd 21090</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Syncope during local anesthesia for bronchoscopy</b><br>DUE TO (b) <b>Bronchogenic carcinoma of rt. lung with</b><br>DUE TO (c) <b>metastatic to liver and lymph nodes</b>  |                                      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Syncope during local anesthesia for bronchoscopy</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>8:15</b> 19 <b>67</b>  |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work <b>Hospital</b>                        |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Balto.</b>  |                                      | 20f. (City or town) (County) (State) <b>Balto. MD.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                      |  |  |
| ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>   |                                      | 22. DATE SIGNED <b>July 5, 1967</b>  |  |
| EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>   |                                      | Address (Street, city, town, or county) <b>German Hill Rd Balto Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>July 8 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State) <b>German Hill Rd Balto Md</b> |
| 24. FUNERAL DIRECTOR <b>The Dippel Brothers Inc 1800 E Lombard St</b>   |                                      | 25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>  |  |
| ADDRESS   |                                      | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION

Report No. 1

Report No. 2

Report No. 3

Report No. 4

Report No. 5

Report No. 6

Report No. 7

6

Report No. 8

Report No. 9

Report No. 10

Report No. 11

Report No. 12

Report No. 13

Report No. 14

Report No. 15

Report No. 16

17

Report No. 17



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

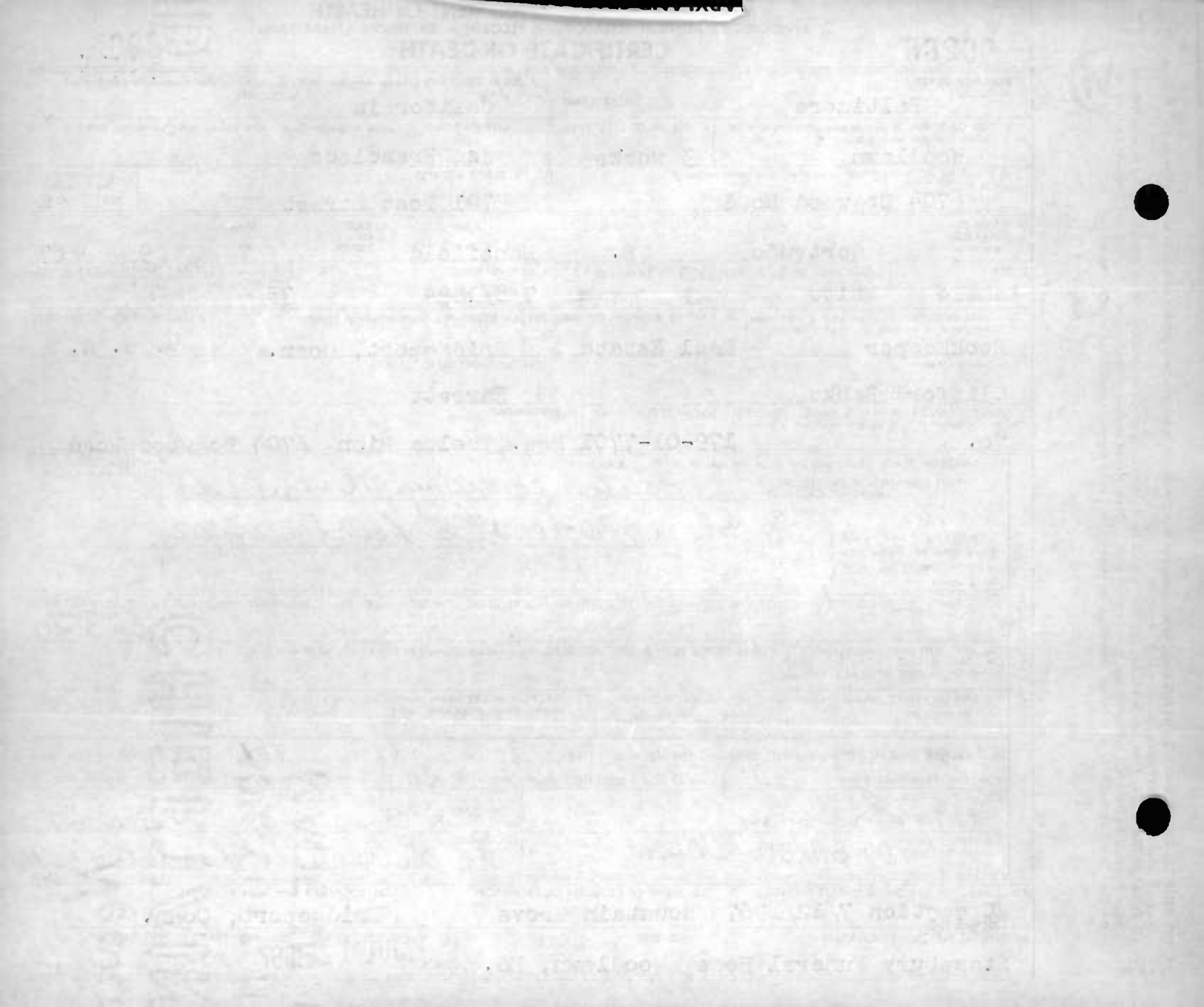
VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09266

09265

|  |                                  |  |                                     |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>California</b> b. COUNTY                            |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Woodlawn</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 weeks</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>6704 Dogwood Road</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>San Francisco</b> <b>43-3</b>                                     |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Gertrude</b> Middle <b>B.</b> Last <b>Mansfield</b>  |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>9</b> Year <b>1967</b>   |                                     |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/8/1894</b> |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>9</b> Hours <b>19</b> Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bookkeeper</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Bridgeport, Conn.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                     |
| 13. FATHER'S NAME<br><b>Clifford Banks</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Barrett</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>179-01-7701</b>  |                                     |
| 17. INFORMANT<br>Address<br><b>Mrs. Thelma Rinn 6704 Dogwood Road</b>  |                                  |  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Acute coronary thrombosis</b><br>DUE TO<br><b>Arterio-sclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-5-1967</b> , to <b>7-9-1967</b> , that (I) (we) last saw the deceased alive on <b>7-5-1967</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above.  |                                  |  |                                     |
| 22a. SIGNATURE<br><b>Dr. Barbu Calin</b>   |                                  | 22b. DATE SIGNED<br><b>7-10-67</b>   |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr BARBU CALIN</b>  |                                  | 22d. ADDRESS<br><b>8811 Liberty Rd Randallstown Md.</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/12/1967</b>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mountain Grove</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Bridgeport, Conn.</b>  |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Stansbury Funeral Home Woodlawn, Md.</b>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 1967</b>   |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |  |                                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09266

09267

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  | c. LENGTH OF STAY IN lb<br><b>3 days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Phoenix, 23.1</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>Box 127, Rte. 1</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>E L M A</b>   |  | First<br><b>G.</b>   |  | Last<br><b>MARKLINE</b>   |  |
| 4. DATE OF DEATH<br><b>July 20 1967</b>  |  | Month<br><b>July</b>   |  | Day<br><b>20</b>  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH<br><b>April 24, 1905</b>  |  | 9. AGE (In years last birthday) yrs.<br><b>62</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland (Towson)</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Harry C. Greaser</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Parks</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No ---</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-48-7579</b>  |  | 17. INFORMANT<br><b>Louis E. Markline</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>331X</b><br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>21131</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>21131</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  | 21. I certify that (1) (this hospital) attended the deceased from <b>July 18</b> , 19 <b>67</b> , to <b>July 20</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>July 20</b> , 19 <b>67</b> , and that death occurred at <b>9:45p</b> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>Jaime Singzon</b>   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>7/20/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jaime Singzon, M.D.</b>   |  | 22d. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/24/1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel</b>   |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Madonna, Maryland</b>  |  | 24. FUNERAL DIRECTOR<br><b>Charles E. Kurtz</b>  |  |   |  |
| 25a. REC'D BY REGISTRAR<br><b>Jarrettsville, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 25c. DATE<br><b>JUL 24 1967</b>   |  |

21084

1952

INDEPENDENT OF

1952

2 days

Home

Harry J. Wheeler

Bethel

250-48-7519

Leola E. Barker

1952

Bethel

1952

Charles A. Carter

1952

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09267

FOR STATE  
HEALTH DEPT

09268

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

58

|   |                                    |   |   |  |   |  |   |
|---|------------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                    |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                    | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>  |                                    |   |   | d. STREET ADDRESS<br><b>1619 E. Chase Street</b>   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>BLEASE</b>   |                                    |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>20</b> Year <b>19 67</b>  |   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 5, 1931</b> |  | 9. AGE (In years last birthday)<br><b>36</b> yrs. |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Labr</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Holley Hill S.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Agnes Martin</b>  |                                    |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Isatell McConer</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO.<br><b>251-44-3367</b>   |   | 17. INFORMANT<br><b>Delois Martin</b> Address  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c)   |                                    |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                    |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/> |                                    |   |   |  |   |  |   |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher</b>  |                                    | EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>  |   | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | 22. DATE SIGNED<br><b>July 22, 1967</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 23b. DATE THEREOF<br><b>7-25-67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore</b>                      |   |
| 24. FUNERAL DIRECTOR<br><b>Eloy O Wilson 1000 Brandywine</b>  |                                    |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 25 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>                                  |   |





09268

09268

## CERTIFICATE OF DEATH

|   |                           |  |                                   |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Towson</b>  |                           | c. LENGTH OF STAY IN lb <b>10 days</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>  |                           | d. STREET ADDRESS <b>613 W. Seminary Avenue</b>  |                                   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Mary Lee Matthews</b>   |                           | 4. DATE OF DEATH <b>July 11 19 67</b>  |                                   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>11/8/1900</b> |
| 9. AGE (In years last birthday) <b>66 yrs.</b>  |                           | 10. IF UNDER 1 YEAR <b>11</b> Months <b>19</b> Days <b>67</b> Hours <b>Min.</b>  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>  |                           | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                   |
| 13. FATHER'S NAME <b>Joshua Staratt</b>   |                           | 14. MOTHER'S MAIDEN NAME <b>Florence Myers</b>   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                           | 16. SOCIAL SECURITY NO. <b>212-32-2639</b>   |                                   |
| 17. INFORMANT <b>Patient's chart</b>  |                           | Address  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive and arteriosclerotic cardiovascular disease</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                           |  |                                   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 1</b> , 19 <b>67</b> , to <b>July 11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 11</b> , 19 <b>67</b> , and that death occurred at <b>6:30 M.</b> from causes and on the date stated above.  |                           |  |                                   |
| 22a. SIGNATURE <b>John E. Adams</b>   |                           | 22b. DATE SIGNED <b>7/11/67</b>  |                                   |
| 22c. PHYSICIAN'S NAME (Type) <b>John E. Adams, M.D.</b>   |                           | 22d. ADDRESS <b>Greater Baltimore Medical Center</b>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                           | 23b. DATE THEREOF <b>7/14/67</b>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>   |                           | 23d. LOCATION (City or Town) (County) (State) <b>Bethesda, Balto. Co. Md.</b>  |                                   |
| 24. FUNERAL DIRECTOR <b>Am. L. Schuman</b>  |                           | 25a. REC'D BY REGISTRAR <b>JUL 13 1967</b>   |                                   |
| ADDRESS <b>1701 M. A. St.</b>   |                           | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED

2002



OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 15, 1902

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1901

ALBANY:

WATKINS & COMPANY, PRINTERS

1902

NEW YORK

STATE OF NEW YORK

IN SENATE

JANUARY 15, 1902

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1901

# FOR STATE HEALTH DEPT

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09269

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk (22)</b>  |  | c. LENGTH OF STAY IN lb<br><b>Dundalk (22)</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7817 Sholar Rd.</b>   |  | d. STREET ADDRESS<br><b>7817 Sholar Rd.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MATILDA</b> Middle <b>MAYESKI</b> Last   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8,</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH<br><b>Feb 9, 1897</b>                                     |
| 9. AGE (In years last birthday) yrs.<br><b>70</b>  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>03-1</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farm Worker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Stanley Bruzdinski</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Murawski</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>216 54 0107</b>   |  |
| 17. INFORMANT<br><b>William Mayeski</b>  |  | Address<br><b>Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4221 @ H-S-C-V- Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>@ Obesity</b><br>(c)  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| EXAMINER'S NAME (Type)<br><b>Melvin B. Davis, M.D. 6800 Mornington Rd.</b>   |  | Address (Street, city, town or county)<br><b>Dundalk, Md. 21222</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/11/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home 1407 Eastern Ave.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 12 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 22. DATE SIGNED<br><b>7/10/67</b>   |  |

**• DO YOU WANT TO:**

Stanley Brandman

SWEST: 1007-1

STP 44-1114 9-10-85

Environ Biol Fish (2015) 98:111–121

H. J. L.

• 210 •

09270

09271

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN lb<br><b>30.4</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore, 21212</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore, 21212</b><br>d. STREET ADDRESS<br><b>5628 Clearspring Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARIE E. MCCARTHY</b><br>First Middle Last<br>4. DATE OF DEATH<br><b>July 6 1967</b><br>Month Day Year  |  | 5. SEX<br><b>female</b><br>6. COLOR OR RACE<br><b>white</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/><br>8. DATE OF BIRTH<br><b>7-25-1899</b><br>9. AGE (In years lost birthday)<br><b>67</b> yrs.<br>IF UNDER 1 YEAR<br>Months Days Hours Min.<br>IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Cashier</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ladies Apparel</b><br>11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b><br>12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Andrew J. Preller</b><br>14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Gaff</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b><br>16. SOCIAL SECURITY NO.<br><b>214-20-2494</b><br>17. INFORMANT<br><b>Miss Anna B. Preller</b><br>Address<br><b>(Same)</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5810</b><br>IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver.</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Acute pulmonary edema.</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b><br>20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 14, 1967</b> , to <b>July 6, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 6, 1967</b> , and that death occurred at <b>1 AM</b> , from causes on and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><b>Dr. Reynaldo Orjuela-Gomez</b><br>22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Reynaldo Orjuela-Gomez</b>   |  | 22b. DATE SIGNED<br><b>July 6, 1967</b><br>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |
| 22d. ADDRESS<br><b>7620 York Rd., Towson, 21204</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>23b. DATE THEREOF<br><b>7/10/1967</b><br>23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b><br>23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b><br>ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 7 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |                              |   |   |  |   |   |  |  |   |
|---|------------------------------|---|---|--|---|---|--|--|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |                              |   |   |  |   |   |  |  |   |
| 09272   |                              |   |   |  | 09271   |   |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Baltimore</i> MARYLAND   |                              |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>MD.</i> b. COUNTY <i>Baltimore</i> |   |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Baltimore</i>  |                              |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Baltimore</i> 031                             |   |   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>NOTRE DAME INFIRMARY - Villa Julia</i>   |                              |   |   |  | d. STREET ADDRESS<br><i>VALLEY ROAD,</i>  |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <i>SISTER REGINA</i> First <i>PATRICE</i> Middle <i>MCCARTHY</i> Last  |                              |   | 4. DATE OF DEATH<br>Month <i>JULY</i> Day <i>15</i> Year <i>1967</i>                                      |  |   |   |  |  |   |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>FEB. 15, 1910</i>  |  | 9. AGE (In years last birthday) <i>57</i> yrs.  | IF UNDER 1 YEAR<br>Months <i>57</i> Days <i>57</i> Hours <i>57</i> Min. <i>57</i> | IF UNDER 24 HRS.<br>Months <i>57</i> Days <i>57</i> Hours <i>57</i> Min. <i>57</i> |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>TEACHER (SISTER)</i>  |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>RELIGIOUS</i>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Philadelphia PA.</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                      |  |   |
| 13. FATHER'S NAME<br><i>DANIEL MCCARTHY</i>   |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><i>REGINA MCCARTY</i>  |   |   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>   |                              |   | 16. SOCIAL SECURITY NO.<br><i>207-40-0584</i>   |  | 17. INFORMANT<br><i>SISTER MARY MARGARET - Villa Julia</i>  |   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinomatosis</i><br><i>1992</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1992</i><br>DUE TO (c) |                              |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 years</i> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |   |  |   |   |  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |   |  |   |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i> p.m.  |                              |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>65</i> , to <i>July 15</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>July 13</i> , 19 <i>67</i> , and that death occurred at <i>2 A</i> M, from the causes and on the date stated above.          |                              |   |   |  |   |   |  |  |   |
| 22a. SIGNATURE<br><i>Harold H Burns</i>   |                              |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><i>July 16, 1967</i>  |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>Harold H Burns</i>   |                              |   |   | 22d. ADDRESS<br><i>8106 Harford Rd. Balt Md</i>  |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                              | 23b. DATE THEREOF<br><i>July 18 1967</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ICHESTER Md</i>   |   | 23d. LOCATION (City, town or county) (State)<br><i>ICHESTER Md</i>                |  |  |   |
| 24. FUNERAL DIRECTOR<br><i>FARLEY-CAVANAUGH</i>   |                              |   |   | ADDRESS<br><i>6601 Frederick Rd</i>  |   | 25a. REC'D BY REGISTRAR<br><i>JUL 20 1967</i>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Jones</i> |   |



09273

CERTIFICATE OF DEATH

09272

|   |  |   |                                   |   |  |  |   |  |
|---|--|---|-----------------------------------|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |   |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                        |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  |   | c. LENGTH OF STAY IN 1b           |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6102 Frederick Rd.</b>   |  |   |                                   | d. STREET ADDRESS<br><b>6102 Frederick Rd.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First <b>Mina</b> Middle <b>E.</b> Last <b>McCurley</b>  |  |   |                                   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>18</b> Year <b>19 67</b>   |  |  |   |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>Cauc.</b>  |                                   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 29, 1886</b> 81 yrs.                                       |   |  |
| 9. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                   | IF UNDER 24 HRS.<br>Hours Min.  |  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Balto., Md.</b>                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Late - Otto C. Emrich</b>   |  |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Von Der Heide</b>   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |                                   | 17. INFORMANT<br><b>Mrs. Margaret Mary McCurley</b><br><b>6102 Frederick Rd. - 21228</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis of the Cardio-Vascular System</b><br>DUE TO<br>(c) |  |   |                                   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo</b><br><b>10 yrs.</b>                                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |                                   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-11-</b> , 19 <b>67</b> , to <b>7-18-</b> , 19 <b>67</b> , that (I) (we) just saw the deceased alive on <b>7-11-</b> , 19 <b>67</b> , and that death occurred at <b>9 A-M</b> , from causes and on the date stated above.   |  |   |                                   |   |  |  |   |  |
| 22a. SIGNATURE<br><b>Wilmer K. Gallagher, Sr.</b>   |  |   |                                   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>7-20-67</b>   |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, Sr.</b>  |  |   |                                   | 22d. ADDRESS<br><b>6209 Frederick Ave.</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>7/21/67</b>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                 |   |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke F. D. - 4101 Edmondson Ave.</b>   |  |   |                                   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 21 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>                                     |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2 a, b, c & d Film #G391 8/11/67 ph & Item #9

09274

CERTIFICATE OF DEATH

09273

|  |                                |  |                                      |
|--|--------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> Pa. b. COUNTY <u>BALTIMORE</u>         |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - CATONSVILLE</u>   |                                | c. LENGTH OF STAY IN lb<br><u>7 MONTHS</u>   |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - CATONSVILLE</u> Pittsburgh 76.3   |                                | d. STREET ADDRESS <u>1010 Shelton Ave.</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>STANGREY - LA NURSING HOME</u>  |                                | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARGARET</u> Middle <u>MCCURRY</u> Last <u>MCCURRY</u>   |                                | 4. DATE OF DEATH<br>Month <u>JULY</u> Day <u>31</u> Year <u>1967</u>   |                                      |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>CAU</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/23/1885</u> |
| 9. AGE (In years last birthday)<br><u>81</u> yrs.  |                                | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u>   |                                | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>ENGLAND</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                      |
| 13. FATHER'S NAME <u>—</u>   |                                | 14. MOTHER'S MAIDEN NAME<br><u>SLOAN</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                                | 16. SOCIAL SECURITY NO. <u>—</u>   |                                      |
| 17. INFORMANT<br><u>DOROTHY BRILL</u>  |                                | Address<br><u>1077 LAKEMONT AVE.</u>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>6000</u> IMMEDIATE CAUSE (a) <u>Septemic</u><br>DUE TO (b) <u>Aschoff's</u><br>DUE TO (c) <u>pericarditis</u>  |                                | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                                | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>66</u> , to <u>7/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/26</u> 19 <u>67</u> , and that death occurred at <u>10A</u> M, from causes and on the date stated above. |                                |  |                                      |
| 22a. SIGNATURE<br><u>Cliff Ratliff, Jr.</u>  |                                | 22b. DATE SIGNED<br><u>7-31-67</u>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Cliff Ratliff, Jr., M.D.</u>  |                                | 22d. ADDRESS<br><u>4605 Edmondson Avenue, Balto, Md., 21229</u>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                | 23b. DATE THEREOF<br><u>8-4-1967</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>CALVARY CEMETERY</u>  |                                | 23d. LOCATION (City or Town) (County) (State)<br><u>PITTSBURG ALLEGHENY PA.</u>  |                                      |
| 24. BURIAL DIRECTOR<br><u>WEBER FUNERAL HOME</u>   |                                | 25a. REC'D BY REGISTRAR<br><u>5311 EDMONDSON AVE</u>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                | DATE<br><u>AUG 2 1967</u>  |                                      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                       |   |   |   |   |  |  |  |  |
|---|--|---------------------------------------|---|---|---|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                       |   |   |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                                       |   |   |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u><br>c. LENGTH OF STAY IN 1b <u>13</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forleigh Nursing Home</u>   |  |                                       |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13-1</u><br>d. STREET ADDRESS <u>610 McHenry Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u>McDermitt</u> Last <u></u>  |  |                                       | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>8</u> Year <u>1967</u>  |   |   |   |  |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u>         |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>2-15-87</u>  |  | 9. AGE (In years last birthday) <u>80</u> yrs.       |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Carpenter</u>   |  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Construction</u>  |   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Waynesboro, Pa.</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>         |  |  |
| 13. FATHER'S NAME<br><u>Hugh McDermitt</u>  |  |                                       |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Cole</u>   |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  |                                       | 16. SOCIAL SECURITY NO.<br><u>579-01-9011</u>   |   | 17. INFORMANT<br>Address <u>Mrs Anna Stratton Baltimore Md.</u>   |   |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4200</u> <u>Arteriosclerotic Heart Disease</u><br>DUE TO (b) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>few years</u> |  |                                       |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>few years</u> |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |  |                                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>July 8</u> , 19 <u>67</u> , that (I) <u>two</u> last saw the deceased alive on <u>8 July</u> 19 <u>67</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.  |  |                                       |   |   |   |   |  |  |  |  |
| 22a. SIGNATURE<br><u>Paul H Royse</u>   |  |                                       |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22b. DATE SIGNED<br><u>July 8 1967</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Paul H Royse</u>   |  |                                       |   |   | 22d. ADDRESS<br><u>1403 Foley L2 Pikesville Md 21088</u>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>7/12/1967</u> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Ignatius Cemetery</u>  |   |   | 23d. LOCATION (City, town or county) (State)<br><u>Ortanna, Adams Co., Pa.</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Robert J. [unclear]</u>  |  |                                       |   |   | ADDRESS<br><u>[unclear]</u>   |   | 25a. REC'D BY REGISTRAR<br><u>JUL 11 1967</u>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[unclear]</u> |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNG3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                               |  |  |   |  |                                  |  |
|--|-------------------------------|--|--|---|--|----------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b><br>c. LENGTH OF STAY IN 1b <b>1 Day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Point Yacht Club</b>  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21206</b><br>d. STREET ADDRESS <b>5703 Whitby Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Gregory</b> Last <b>Megee</b>   |                               | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1967</b>  |  |   |  |                                  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec. 11, 1961</b>  | 9. AGE (In years last birthday) <b>5</b> yrs.   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>03</b> Days <b>1</b> Hours <b>1</b> Min. |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>  |  |                                  |  |
| 13. FATHER'S NAME <b>James G. Megee</b>  |                               |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                               |  | 16. SOCIAL SECURITY NO. <b>none</b>  |   |  |                                  |  |
| 17. INFORMANT <b>Mr &amp; Mrs James G. Megee</b>   |                               |  | Address <b>5703 Whitby RD.</b>   |   |  |                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DROWNING</b><br>9298<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>           |                               |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Wandered away &amp; apparently fell into water.</b>      |  |   |  |                                  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>July 1967</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Not Near</b> | 20f. (City or town) <b>Sparrows Pt - Balto Md</b>   | (County) (State)   |                                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |  |   |  |                                  |  |
| ACTUAL SIGNATURE <b>M.B. Davis</b>   |                               | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |                                  |  |
| EXAMINER'S NAME (Type) <b>M.B. DAVIS - MD - 6801</b>   |                               | 22. DATE SIGNED <b>7/13/67</b>   |  |   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>7/6/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>                           |   | 23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>                 |                                  |  |
| 24. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons inc. Balto. MD.</b>  |                               |  | 25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>  |   |  |                                  |  |
|  |                               |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   |  |                                  |  |

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Baltimore, Maryland

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Carol A. Kopy

Carol A. Kopy

12-11-51 (Carol A. Kopy)

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Baltimore, Maryland

Baltimore, Maryland

Baltimore, Maryland

Henry Sender & Sons Inc. Baltimore, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |   |   |   |  |  |                                  |  |
|--|--|----------------------------------|---|---|---|---|---|--|--|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD.  |  |                                  |   |   |   |   |   |  |  |                                  |  |
| 09278 CERTIFICATE OF DEATH 09277   |  |                                  |   |   |   |   |   |  |  |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>c. LENGTH OF STAY IN 1b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chapel Hill Nursing Home</b>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>d. STREET ADDRESS <b>3924 Susanna Rd</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |  |                                  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Edna</b> Middle <b>G.</b> Last <b>Melvin</b>   |  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>7</b> Year <b>1967</b>                                       |   |   |   |   |  |  |                                  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>    |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Sept 5, 1893</b> |   | 9. AGE (In years birthdate) <b>73</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min. |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore city</b>   |   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |                                  |  |
| 13. FATHER'S NAME <b>Joshua O. Griffith</b>  |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME <b>Agnes Naughton</b>  |   |   |  |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  |                                  | 16. SOCIAL SECURITY NO. <b>none</b>   |   | 17. INFORMANT <b>3429 Susanna Rd. Mrs. Doris Manley Randallstown, Md</b>  |   |   |  |  |                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4500</b> DUE TO (b) <b>Dehydration + difficulty in swallowing</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Generalized Arteriosclerosis + Parkinson's Disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Numerous Large Decubiti</b> |  |                                  |   |   |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |   |   |   |   |  |  |                                  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                              |  |  |                                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-15-1967</b> , to <b>7-7-1967</b> , that (I) (we) last saw the deceased alive on <b>7-7-1967</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.  |  |                                  |   |   |   |   |   |  |  |                                  |  |
| 22a. SIGNATURE <b>Cesar Valle Cervero</b>  |  |                                  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>7/8/67</b>                                    |  |  |                                  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr, Cesar Valle Cervero</b>  |  |                                  |   |   | 22d. ADDRESS <b>8629 Liberty Rd. Randallstown, Md.</b>  |   |   |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>7/10/67</b> |   | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>   |   |   | 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b> |  |  |                                  |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers</b> ADDRESS <b>8728 Liberty Rd Randallstown, Md.</b>  |  |                                  |   |   | 25a. REC'D BY REGISTRAR <b>JUL 10 1967</b> DATE   |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                     |  |  |                                  |  |

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Religious City

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Figure 1. Study area.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove rubber papers. Pages 1 and 2 must be retained within 72 hours after death.

|  |                            |   |   |
|--|----------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MIKUCKIS, PAULINA</b>  |                            | 2. DATE AND HOUR OF DEATH<br><b>7/3/67 4:22 A</b>   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>Baltimore County</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>SHANGRI-LA NURSING HOME</b><br><b>333 HARLEM LANE, BALTO + 28</b>   |                            | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1914 LETITIA AVE</b> |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b>        | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>  | 8. DATE OF BIRTH<br><b>12/22/07</b>   |
| 9. AGE (In years last birthday)<br><b>59</b>   |                            | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                            | 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>LITHUANIA</b>  |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Agejus Vakselis</b>  |                            | 14. MOTHER'S MAIDEN NAME<br><b>Stefanie</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                            | 16. SOCIAL SECURITY NO.<br><b>214-30-6006</b>   |   |
| 17. INFORMANT<br><b>CHART</b>  |                            | ADDRESS   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>1930</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>1930</b> |                            | CAUSE OF DEATH<br><b>1) BRAIN TUMOR</b><br><b>2) GLIOMA</b><br><b>3) GRAND MAL SEIZURES</b><br><b>4) DIABETES MELLITUS</b><br><b>5) RECURRENT URINARY TRACT INFECTIONS</b>  |   |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>4y.</b>   |                            | 20. INTERVAL BETWEEN ONSET AND DEATH<br><b>2y.</b>  |   |
| 21. INTERVAL BETWEEN ONSET AND DEATH<br><b>2y.</b>   |                            | 22. INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo</b>   |   |
| 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                            |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOV 14 1966</b> to <b>JULY 3 1967</b> that (I) (we) last saw the deceased alive on <b>July 1 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                |                            |   |   |
| 23A. SIGNATURE<br><b>E. KASAITIS</b>   |                            | 23B. DATE SIGNED<br><b>7/3/67</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>E. KASAITIS, M.D.</b>   |                            | 23D. ADDRESS<br><b>1801 FREDERICK RD</b><br><b>BALTIMORE, MD 21228</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   | 24B. DATE<br><b>7-7-67</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><b>JUL 6 1967</b>  |                            | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |   |

13610-90-2420000

87500

| GENERAL INFORMATION |  |  |  | SPECIFIC DATA |  |  |  |
|---------------------|--|--|--|---------------|--|--|--|
| NAME                |  |  |  | DATE          |  |  |  |
| ADDRESS             |  |  |  | TIME          |  |  |  |
| 1. NAME             |  |  |  | 2. DATE       |  |  |  |
| 3. ADDRESS          |  |  |  | 4. TIME       |  |  |  |
| 5. NAME             |  |  |  | 6. DATE       |  |  |  |
| 7. ADDRESS          |  |  |  | 8. TIME       |  |  |  |
| 9. NAME             |  |  |  | 10. DATE      |  |  |  |
| 11. ADDRESS         |  |  |  | 12. TIME      |  |  |  |
| 13. NAME            |  |  |  | 14. DATE      |  |  |  |
| 15. ADDRESS         |  |  |  | 16. TIME      |  |  |  |
| 17. NAME            |  |  |  | 18. DATE      |  |  |  |
| 19. ADDRESS         |  |  |  | 20. TIME      |  |  |  |
| 21. NAME            |  |  |  | 22. DATE      |  |  |  |
| 23. ADDRESS         |  |  |  | 24. TIME      |  |  |  |
| 25. NAME            |  |  |  | 26. DATE      |  |  |  |
| 27. ADDRESS         |  |  |  | 28. TIME      |  |  |  |
| 29. NAME            |  |  |  | 30. DATE      |  |  |  |
| 31. ADDRESS         |  |  |  | 32. TIME      |  |  |  |
| 33. NAME            |  |  |  | 34. DATE      |  |  |  |
| 35. ADDRESS         |  |  |  | 36. TIME      |  |  |  |
| 37. NAME            |  |  |  | 38. DATE      |  |  |  |
| 39. ADDRESS         |  |  |  | 40. TIME      |  |  |  |
| 41. NAME            |  |  |  | 42. DATE      |  |  |  |
| 43. ADDRESS         |  |  |  | 44. TIME      |  |  |  |
| 45. NAME            |  |  |  | 46. DATE      |  |  |  |
| 47. ADDRESS         |  |  |  | 48. TIME      |  |  |  |
| 49. NAME            |  |  |  | 50. DATE      |  |  |  |
| 51. ADDRESS         |  |  |  | 52. TIME      |  |  |  |
| 53. NAME            |  |  |  | 54. DATE      |  |  |  |
| 55. ADDRESS         |  |  |  | 56. TIME      |  |  |  |
| 57. NAME            |  |  |  | 58. DATE      |  |  |  |
| 59. ADDRESS         |  |  |  | 60. TIME      |  |  |  |
| 61. NAME            |  |  |  | 62. DATE      |  |  |  |
| 63. ADDRESS         |  |  |  | 64. TIME      |  |  |  |
| 65. NAME            |  |  |  | 66. DATE      |  |  |  |
| 67. ADDRESS         |  |  |  | 68. TIME      |  |  |  |
| 69. NAME            |  |  |  | 70. DATE      |  |  |  |
| 71. ADDRESS         |  |  |  | 72. TIME      |  |  |  |
| 73. NAME            |  |  |  | 74. DATE      |  |  |  |
| 75. ADDRESS         |  |  |  | 76. TIME      |  |  |  |
| 77. NAME            |  |  |  | 78. DATE      |  |  |  |
| 79. ADDRESS         |  |  |  | 80. TIME      |  |  |  |
| 81. NAME            |  |  |  | 82. DATE      |  |  |  |
| 83. ADDRESS         |  |  |  | 84. TIME      |  |  |  |
| 85. NAME            |  |  |  | 86. DATE      |  |  |  |
| 87. ADDRESS         |  |  |  | 88. TIME      |  |  |  |
| 89. NAME            |  |  |  | 90. DATE      |  |  |  |
| 91. ADDRESS         |  |  |  | 92. TIME      |  |  |  |
| 93. NAME            |  |  |  | 94. DATE      |  |  |  |
| 95. ADDRESS         |  |  |  | 96. TIME      |  |  |  |
| 97. NAME            |  |  |  | 98. DATE      |  |  |  |
| 99. ADDRESS         |  |  |  | 100. TIME     |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09280

09279

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b <b>2 yrs.</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>16 Fusting Ave.</b>  |   | d. STREET ADDRESS <b>104 Woodlawn Ave.</b><br><b>16 Fusting Ave.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>SARA CONWAY MILLER</b>   |   | 4. DATE OF DEATH <b>July 3</b><br>Month <b>July</b> Day <b>3</b> Year <b>1967</b>   |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>Caucasian</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>March 24, 1891</b><br>9. AGE (In years lost birthday) <b>76</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>CHARLES COOK CONWAY</b>   |   | 14. MOTHER'S MAIDEN NAME <b>LIZZIE GRAY ADAMS</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |   | 16. SOCIAL SECURITY NO. <b>215-10-3311</b>  |  |
| 17. INFORMANT <b>Alice Kanley</b>  |   | Address <b>104 Woodlawn Ave. Balto. 21228</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b><br>DUE TO <b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Broncho-pneumonia</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 24<sup>th</sup></b> , 19 <b>67</b> , to <b>July 3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 23</b> , 19 <b>67</b> , and that death occurred at <b>1<sup>st</sup></b> P.M., from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE <b>Wetherbee Fort</b>   |   | 22b. DATE SIGNED <b>7/3/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Wetherbee Fort</b>   |   | 22d. ADDRESS <b>6 Dutton Ave, Catonsville 28.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>7/6/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>                       |
| 24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</b>  |   | 25a. REC'D BY REGISTRAR <b>JUL 7 1967</b><br>DATE   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09280

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>—</b>                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spam Pt - 19</b>   |   | c. LENGTH OF STAY IN 1b <b>—</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kumal Mt. Pleasure Club</b>  |   | d. STREET ADDRESS <b>4913 Denmore Ave.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Theresa</b> Middle <b>Anne</b> Last <b>Minko</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>9th.</b> Year <b>19 67</b>  |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>Cau.</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>June 29, 1948</b>   |
| 9. AGE (in years last birthday) <b>19</b> yrs.   |   | IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-typist</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>—</b>  |   |
| 13. FATHER'S NAME <b>John Minko</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Mary Ann Gregory</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO. <b>216-52-9727</b>   |   |
| 17. INFORMANT <b>John Minko, 4913 Denmore Ave.</b>   |   | Address <b>—</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DROWNING</b><br>DUE TO <b>9298</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>—</b><br>(a), stating the underlying cause lost. DUE TO (c) <b>—</b>   |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>—</b>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>  |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 8.) <b>Slipped from Saw Bar into deep water</b>                  |   |
| 20c. TIME OF INJURY<br>Hour <b>2:00</b> p.m. Month, Day, Year <b>7-9 1967</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ches. Bay</b>  | 20f. City or town <b>Spam Pt.</b> (County) <b>Balto. Md.</b> (State) <b>Md.</b> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE <b>M B Davis</b>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| 6800 Morningson Rd.  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>—</b>  | 22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>   | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>             |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Vernon Gannon</b>   |   | 4611 Park Heights Ave. Balto.  |   |
| 24a. REG'DAY REGISTRAR <b>JUL 11 1967</b>  |   | 24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09281

FOR STATE  
HEALTH DEPT.

09282

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 Year</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1803 Homberg Avenue</b>  |                                  | e. STREET ADDRESS<br><b>1803 Homberg Avenue 21221</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LEWIS DORSEY MITCHELL</b>  |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>5</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/24/38</b>           |
| 9. AGE (In years last birthday)<br><b>28 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>28</b> Days <b>03</b> Hours <b>1</b> Min.  | 11. IF UNDER 24 HRS.<br>Hours <b>03</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Hot Strip Mill</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel Co.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>H. Louis Mitchell</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ethel Wilson</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1956-1959</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>212-36-2749</b>   |  |
| 17. INFORMANT (Sister) <b>Balto. Md. 21201</b>  |                                  | 18. Mrs. Garnette Logan, 863 N. Howard St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrocranial injuries</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Multiple impacts to head</b><br>DUE TO<br>(c)   |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Struck multiple times with an axe</b>                    |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>?</b> p.m. <b>7 5 1967</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Baltimore Balto. Md.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE<br><i>Charles S. Springate</i>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>CHARLES S. SPRINGATE, M.D.</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |                                  | 22. DATE SIGNED<br><b>7-6-67</b>  |  |
| Address (Street, city, town, or county)   |                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/10/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l. Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Springate</i>  |                                  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

09283

09282

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>7 yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Stella Maris Hospice</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Md</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>8361 Ridgely Oak Rd</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Dorothy Katherine Moeller</b><br>First Middle Last   |  |   |  | 4. DATE OF DEATH<br><b>7/31/67</b><br>Month Year  |  |   |  |
| 5. SEX<br><b>F</b>   |  | 6. COLOR OR RACE<br><b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>4/16/1890</b>  |  |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days  |  | 11. IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Hswf</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Peter Unkelbach</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Dora Ulrich</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>220-46-0763</b>   |  | 17. INFORMANT<br><b>Hospice records</b><br>Address                          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e)<br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }<br><b>Coronary Thrombosis</b><br><b>ASCD</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/4/59</b> , 19....., to <b>7/31/67</b> , 19....., that (I) (we) last saw the deceased alive on <b>7/31/67</b> , 19....., and that death occurred at <b>10:09 PM</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Robert J. Mahon</b><br>M.D.   |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>7/31/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert Mahon, M.D.</b>  |  |   |  | 22d. ADDRESS<br><b>204 E. Joppa Rd. Towson</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>8/4/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b><br>ADDRESS  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 2 1967</b><br>DATE  |  |   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Balto. City</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   | c. LENGTH OF STAY IN 1b<br><u>9 days</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Greater Baltimore Med. Center</u>  |   | d. STREET ADDRESS<br><u>5601 Newbury Ave.</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Christina Heimleu Nornberger</u>  |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>29</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-18-01</u>  |
| 9. AGE (In years lost birthday)<br><u>65</u> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>estimator</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Balto. md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Henry Nornberger</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Heimleu</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>316-32-9263</u>   |  |
| 17. INFORMANT<br><u>patient's chart</u>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u><br>DUE TO (b) <u>prof. internal hemorrhage</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> <u>19</u><br>p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/20/67</u> , 19 <u>67</u> , to <u>7/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/29</u> , 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>Parviz Navidi</u>  |   | 22b. DATE SIGNED<br><u>7/29/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Gilmore</u>  |   | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>August 2, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Pikesville, Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>George Funeral - 3624 Falls Rd.</u><br><u>William R. Kleiber</u>   |   | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |  |
| 25b. REGISTRAR'S SIGNATURE  |   | DATE<br><u>AUG 3 1967</u>   |  |

*Quercus agrifolia* Nutt.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09285

CERTIFICATE OF DEATH

09284

|   |                                  |   |   |   |   |   |   |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>    |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                  | c. LENGTH OF STAY IN lb<br><u>9 days</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson 21204</u>   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Greater Baltimore Medical Center</u>   |                                  |   |   | d. STREET ADDRESS<br><u>24 Acorn Circle</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Margaret</u> First <u>MNV</u> Middle <u>Marrison</u> Last   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>7</u> Year <u>1967</u>   |   |   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 25, 1893</u> | 9. AGE (In years last birthday) <u>73</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>19</u> Hours <u>6</u> Min. |   | IF UNDER 24 HRS.<br>Hours <u>6</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Scotland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Robert Stevenson</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Steele, Janet</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><u>Unk.</u>  |   | 17. INFORMANT<br><u>Mrs. Janet Stahl</u>  |   | Address<br><u>(Same)</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4221 Congestive Heart Failure</u><br>DUE TO (b) <u>Arteriosclerotic Cardiovascular and Rheumatic Heart Disease</u><br>DUE TO (c) <u>Heart Disease</u> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u> p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1967</u> , to <u>July 6, 1967</u> ; that (I) (we) last saw the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>2:35 PM</u> , from causes and on the date stated above.                |                                  |   |   |   |   |   |   |
| 22a. SIGNATURE<br><u>Jose M. de Leon</u>  |                                  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><u>7/6/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOSE M. DE LEON</u>  |                                  |   |   | 22d. ADDRESS<br><u>Greater Balto. Med. Center</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |                                  | 23b. DATE THEREOF<br><u>7/8/67</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount Crematory</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |   |
| 24. FUNERAL DIRECTOR<br><u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 10 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jago</u>  |   |

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## CERTIFICATE OF DEATH

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|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  | c. LENGTH OF STAY IN lb<br><b>37 DAYS</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>1640 N. FULTON AVENUE</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>LAWRENCE E. NAPPER</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 17 19 67</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/6/23</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CAB DRIVER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TAXICAB COMPANY</b>  | 9. AGE (In years birth day) yrs. <b>44</b>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>ALEXANDRIA, VIRGINIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>RICHARD NAPPER</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA MN: CHASE</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES PL 28</b>   |  | 16. SOCIAL SECURITY NO.<br><b>225 28 21 25</b>   |   |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b><br>DUE TO (b) <b>Carcinoma left lung with</b><br>DUE TO (c) <b>metastasis to rt lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>recent</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/10/67</b> , 19 to <b>7/17/67</b> , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7/17/67</b> , 19, and that death occurred at <b>10:15 PM</b> , from causes on and on the date stated above                |  |  |   |
| 22a. SIGNATURE<br><b>Ahmed Kutty</b>  |  | 22b. DATE SIGNED<br><b>7/18/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>AHMED C.K. KUTTY M.D.</b>  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>7/21/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SNOWDEN CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>ALEXANDRIA, VIRGINIA</b>                      |
| 24. FUNERAL DIRECTOR<br><b>Kileen E. Egan</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 21 1967</b>  |   |
| 25b. GREEN FUNERAL HOME<br><b>814 FRANKLIN ST. ALEXANDRIA, VA.</b>  |  | 25c. REG. NO. & SIGNATURE<br><b>Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## ROUTINES

DATE FOR NOTATION INIA. 00000000

CONCLUSIONS

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TRANSFER PLACEMENT

ALPHABETICALLY

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

7/3/15/7

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |   |   |   |  |   |   |  |
|--|--|-------------------------------|---|---|---|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |   |   |   |  |   |   |  |
| CERTIFICATE OF DEATH   |  |                               |   |   |   |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>c. LENGTH OF STAY IN 1b<br><b>13-1</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3429 Chapman Road</b>   |  |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>d. STREET ADDRESS <b>3429 Chapman Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>Nickoles</b> Last <b>Nickoles</b>   |  |                               |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>6</b> Year <b>1967</b>   |  |   |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>white</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>March 25, 1987</b>                                     |   | 9. AGE (In years last birthday) <b>80</b><br>IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b><br>IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>  |   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co. Md.</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>Albert Nickoles</b>   |  |                               |   |   | 14. MOTHER'S MAIDEN NAME <b>Margaret Laughterbaugh</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |  |                               | 16. SOCIAL SECURITY NO. <b>215-32-1900</b>  |   | 17. INFORMANT <b>3429 Chapman Rd. Mrs. Bessie M. Nickoles Randallstown, Md</b>  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>4201</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HAS CVD</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |  |                               |   |   |   |  |   |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                               |   |   |   |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3/13/1963</b> , to <b>6/26/1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>6/26/1967</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.   |  |                               |   |   |   |  |   |   |  |
| 22a. SIGNATURE <b>John Darrell</b>   |  |                               |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   | 22b. DATE SIGNED <b>7/8/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. John J. Darrell</b>  |  |                               |   |   | 22d. ADDRESS <b>9017 Liberty Road, Randallstown. Md.</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (specify) <b>burial</b>  |  |                               | 23b. DATE THEREOF <b>7/10/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Memorial</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Liberty Rd, Carroll Co, Md.</b> |   |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers</b> ADDRESS <b>8728 Liberty Rd. Randallstown Md.</b>  |  |                               |   |   | 25a. REC'D BY REGISTRAR <b>JUL 10 1967</b> DATE   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>                              |   |  |

THE PEOPLE OF DEATH

Bartholomew  
Bartholomew

3439 Chapman Road

March 1, 1987 80

March 1, 1987 80

Bartholomew Co. Ind.

Bartholomew Co. Ind.

3439 Chapman Road

Bartholomew Co. Ind. 3439 Chapman Road

3439 Liberty Road, Bartholomew, Ind.

Bartholomew Co. Ind.

Bartholomew Co. Ind. 3439 Liberty Road



TO HOSPITALS AND ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 7-62

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |                               |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>TOWSON Balto.</b> 21212<br>c. LENGTH OF STAY IN b <b>33 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ARMACOST NURSING HOME</b>  |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON, MD.</b><br>d. STREET ADDRESS <b>934 DULANEY VALLEY RD.</b> 0311<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE V. NIGHTINGALE</b>  |  |                               |  |  |  | 4. DATE OF DEATH Month Day Year <b>JULY 4, 1967</b>  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>MAY 31, 1891</b>   |  | 9. AGE (In years last birthday) <b>76</b> yrs.                               |  | 10. IF UNDER 1 YEAR Months Days |  | 11. IF UNDER 24 HRS. Hours Min.  |  |  |  |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES MANAGER</b>  |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>WOOD FLOORING</b>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>PHILADELPHIA, PA.</b> |  |                                 |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <b>GEORGE NIGHTINGALE</b>   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <b>SARAH DOTTS</b>  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)  |  |                               |  |  |  | 16. SOCIAL SECURITY NO. <b>160-07-6381</b>   |  |  |  |                                 |  | 17. INFORMANT Address <b>IRMA L. NIGHTINGALE, SAME AS ABOVE</b>                              |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary arrest</b><br>4330 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO <b>Coronary vascular accident with left hemiparesis</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b><br><b>Several years</b><br><b>4 months</b> |  |                               |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  |  |  |  |  |  |  |                                 |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>  |  |                               |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |                                 |  | 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>July</b> , 1967, that (I) (we) last saw the deceased alive on <b>July</b> , 1967, and that death occurred at <b>4:15</b> A.M. from the causes and on the date stated above.   |  |                               |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>S. J. Liu</b> M.D.  |  |                               |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>July 4, 1967</b>   |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>S. J. Liu M.D.</b>  |  |                               |  |  |  | 22d. ADDRESS <b>5301 Harford Rd. Baltimore Md.</b>   |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>  |  |                               |  | 23b. DATE THEREOF <b>7-4-67</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS HOSPITAL</b>             |  |                                 |  | 23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MD.</b>                           |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harbina, DELTA, PA.</b>   |  |                               |  |  |  | 25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>  |  |  |  |                                 |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |  |  |  |  |  |  |  |  |

Figure 1

14

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                           |  |  |   |  |   |  |  |
|--|--|---------------------------|--|--|---|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |  |  |   |  |   |  |  |
| 09288 CERTIFICATE OF DEATH 09288   |  |                           |  |  |   |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u><br>c. LENGTH OF STAY IN 1b <u>18 1/2</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>                        |  |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>1333 Dillon Hgts. Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>George</u>  |  |                           | First Middle Last  |  | 4. DATE OF DEATH <u>7</u> <u>24</u> <u>19 67</u>  |  | Month Day Year  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>7-12-80</u>  |   | 9. AGE (In years last birthday) <u>87</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>   |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |   | 11. BIRTHPLACE (County & State, or foreign country) <u>xxxxxx New York</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Jacob Nunnold</u>   |  |                           |  | 14. MOTHER'S MAIDEN NAME <u>Josephine Messner</u>  |   |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |                           |  | 16. SOCIAL SECURITY NO. <u>219-05-9180</u>   |   | 17. INFORMANT Address <u>Mrs. Thelma B. Arold, 1560 Lister Rd. 21227</u>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia (G.U.)</u><br><u>0533</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                           |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>   |  |                           |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                              |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> , 19 <u>67</u> , to <u>7-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>67</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.                                |  |                           |  |  |   |  |   |  |  |
| 22a. SIGNATURE <u>David I. Miller</u> M.D.   |  |                           |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED <u>7-24-67</u>                                   |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>  |  |                           |  |  | 22d. ADDRESS <u>Linson Rd. - Owings Mills, Md.</u>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                           | 23b. DATE THEREOF <u>7/27/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u> |  |  |
| 24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>   |  |                           |  |  | 25a. REC'D BY REGISTRAR <u>JUL 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |   |  |  |

3202

09288

## CERTIFICATE OF DEATH

09288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                              |  |  |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b><br>c. LENGTH OF STAY IN 1b<br><b>81 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Mount Wilson State Hospital</b> |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>City</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21215</b><br>d. STREET ADDRESS<br><b>4708 Wilern Ave</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Rose Fannie Obertier</b>   |                              | 4. DATE OF DEATH<br>Month<br><b>July</b><br>Day<br><b>31</b><br>Year<br><b>1967</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>4-21-11</b><br>9. AGE (In years last birthday)<br><b>56</b><br>yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ohio</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Samuel Hunovice</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Hunovice</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>214-165029</b>   |  |
| 17. INFORMANT<br><b>Records, Mount Wilson State Hospital</b>  |                              | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Obstructive Air Way Disease</b><br><b>5-71</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with Failure</b><br>DUE TO (c)       |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-1</b> , 19 <b>67</b> to <b>7-21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-21</b> , 19 <b>67</b> , and that death occurred at <b>10:50</b> AM, from causes on and on the date stated above.  |                              |  |  |
| 22a. SIGNATURE<br><b>W. Newcomer</b>  |                              | 22b. DATE SIGNED<br><b>7-21-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>   |                              | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>7/23/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mikro Kodesh Beth Israel</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>JUL 26 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>James Jones</b>  |  |



RECEIVED  
JAN 20 1954  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

OFFICE OF THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

MEMORANDUM FOR THE SECRETARY OF AGRICULTURE  
SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SERIAL: [Illegible]

FILE: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09291

09290

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>BALTO.</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>125 Waelchli Ave. 21227</b>  |  | d. STREET ADDRESS<br><b>125 Waelchli Ave. 21227</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>E.</b> Last <b>O'Loughlin</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/9/87</b>                                     |
| 9. AGE (In years last birthday) yrs.<br><b>79</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Peter F. O'Loughlin</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie E. Gisell</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><b>212-10-6391</b>   |   |
| 17. INFORMANT<br><b>Mrs. Edith E. O'Loughlin, 125 Waelchli Ave.</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4221 Congestive Failure</b><br>DUE TO (b) <b>Arterio Sclerotic Cardiovascular Disease</b><br>DUE TO (c) <b>Osteoar.</b>          |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 7/9, 1967</b> to <b>7/9, 1967</b> , that (I) (we) last saw the deceased alive on <b>7/9 1967</b> , and that death occurred at <b>7/9 1967</b> M, from causes and on the date stated above |  |   |   |
| 22a. SIGNATURE<br><b>James N. Frederick</b>   |  | 22b. DATE SIGNED<br><b>7/10/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James N. Frederick</b>   |  | 22d. ADDRESS<br><b>1311 Francis Ave. CI2-5200</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/12/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1967</b>   |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

1939

CERTIFICATE OF MARRIAGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

CERTIFICATE OF DEATH

09292

09291

|   |                                  |   |                                       |  |                           |   |  |
|---|----------------------------------|---|---------------------------------------|--|---------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |                                  |   |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> |                           |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>6 mos. 3 days</b>   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE #21224</b>                          |                           |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove S. Hospital</b>   |                                  |   |                                       | d. STREET ADDRESS<br><b>507 S. 48th St.</b>  |                           | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>EVA K. OLSEN.</b>   |                                  |   |                                       | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>4</b> Year <b>1967</b>   |                           |   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-14-1898</b> | 9. AGE (In years last birthday)<br><b>73</b> yrs.  | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS.<br>Days  | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSE WORK</b>  |                                       | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MD.</b>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>FRANCIS JONECKI</b>   |                                  |   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>LOUISE J. KNUSZCZYNSKI</b>  |                           |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>218-01-2980</b>   |                                       | 17. INFORMANT<br><b>Spring Grove S. Hosp. Records</b>  |                           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4330</b><br>IMMEDIATE CAUSE (a) <b>CARDIAC Arrest.</b><br>DUE TO (b) <b>Arteriosclerotic Cardiovasc. disease</b><br>DUE TO (c) <b>Generalized Arteriosclerosis.</b>     |                                  |   |                                       |  |                           |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes Mellitus - Pneumonia.</b>   |                                  |   |                                       |  |                           |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |  |                           |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>67</b> to <b>7-4</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>7-4</b> , 19 <b>67</b> , and that death occurred at <b>6:30</b> M, from causes and on the date stated above. |                                  |   |                                       |  |                           |   |  |
| 22a. SIGNATURE<br><b>Narciso W. Carmona</b>   |                                  |   |                                       | 22b. DATE SIGNED<br><b>7-4-67</b>  |                           | 22c. PHYSICIAN'S NAME (Type)<br><b>NARCISO W. CARMONA</b>   |  |
| 22d. ADDRESS<br><b>Spring Grove S. Hospital</b>   |                                  |   |                                       | 22e. ADDRESS<br><b>Spring Grove S. Hospital</b>  |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>7-8-67</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEM.</b>   |                           | 23d. LOCATION (City or Town) (County) (State)<br><b>CT 7225 EASTERN BLVD. BA CO., MD.</b>         |  |
| 24. FUNERAL DIRECTOR<br><b>Charles A. Zeiler</b>  |                                  |   |                                       | 25a. REC'D BY REGISTRAR<br><b>JUL 6 1967</b>   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Judge</b>  |  |

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FOR STATE  
HEALTH DEPT.

09293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09292

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Middle River (20)</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex (21)</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Martin's Lagoon</b>   |                                  | d. STREET ADDRESS<br><b>1400 Nicholay Way</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Paul Omregcik, Jr.</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>29</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Feb 25, 1952</b>  |
| 9. AGE (In years lost birthday)<br><b>15</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>03</b> Hours <b>1</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Paul Omregcik, Sr.</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Nichols</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Rebecca Omregcik</b>   |                                  | Address<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>929.8  |                                  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Subject was swimming across lagoon, yelled for help and disappeared beneath surface of water.</b> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>3:30</b> a.m. <b>7/28</b> 19 <b>67</b> p.m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Martins Lagoon</b>  |                                  | 20f. (City or town) (County) (State)<br><b>Essex Balto Md.</b>   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |  |
| ACTUAL SIGNATURE<br><b>Theo C Patterson</b>  |                                  | 22. DATE SIGNED<br><b>7/31/67</b>  |  |
| EXAMINER'S NAME (Type)<br><b>Theo. C. Patterson, M. D.</b>   |                                  | 105 Main St. Dundalk, Md. 21222  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>8/1/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>James Bruzdinski</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 31 1967</b>  |  |
| ADDRESS<br><b>1407 Eastern Ave.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                   |   |  |   |                                  |  |  |  |                                  |  |
|--|--|-----------------------------------|---|--|---|----------------------------------|--|--|--|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                   |   |  |   |                                  |  |  |  |                                  |  |
| 09294 CERTIFICATE OF DEATH 09293   |  |                                   |   |  |   |                                  |  |  |  |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b><br>c. LENGTH OF STAY IN ID <b>1 Year</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>944 Elmridge Ave.</b>   |  |                                   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b><br>d. STREET ADDRESS <b>944 Elmridge Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |  |  |  |                                  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Louisa M.</b> Middle <b>Panzone</b> Last <b></b>   |  |                                   |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>14,</b> Year <b>19 67</b>  |                                  |  |  |  |                                  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>     |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>3-9-1886</b> |  | 9. AGE (In years last birthday) <b>81</b> yrs. |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY |   | 11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>   |   |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                                       |  |  |                                  |  |
| 13. FATHER'S NAME <b>Felice De Nicola</b>  |  |                                   |   |  | 14. MOTHER'S MAIDEN NAME <b>Gaetano Matucci</b>   |                                  |  |  |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |                                   |   |  | 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT <b>Vincent Panzone 2542 W. Lanvale St.</b> Address <b>Balto. Md.</b> |  |  |                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Atherosclerosis</b><br>DUE TO (b) <b>Terminal Myocardial</b><br>DUE TO (c) <b>Infarction</b><br>CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                                   |   |  |   |                                  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                   |   |  |   |                                  |  |  |  |                                  |  |
| MEDICAL CERTIFICATION  |  |                                   |   |  |   |                                  |  |  |  |                                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |  |  |  |                                  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |  |                                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>11:00</b> M. from the causes and on the date stated above.  |  |                                   |   |  |   |                                  |  |  |  |                                  |  |
| 22a. SIGNATURE <b>John E. Healey</b> M.D.  |  |                                   |   |  | 22b. DATE SIGNED <b>7/17/67</b>   |                                  |  |  |  |                                  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Healey, John E.</b>  |  |                                   |   |  | 22d. ADDRESS <b>Baltimore, Md.</b>  |                                  |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                                   | 23b. DATE THEREOF <b>July 17, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>  |                                  | 23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>                     |  |  |                                  |  |
| 24. FUNERAL DIRECTOR <b>G. Truman Schwab 3512 Frederick Ave, Balto. Md.</b> ADDRESS  |  |                                   |   |  | 25a. REC'D BY REGISTRAR <b>JUL 19 1967</b>  |                                  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                    |  |  |                                  |  |

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Baltimore

Admission

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Admission

1111 Exchange Ave.

1111 Exchange Ave.

James H. Johnson

July 14

Female White

7-1-1937

11

Home Wife

Italy

U. S. A.

Police de Chicago

Chicago National

Winnetka Avenue 1245 N. Lawrence St.

Chicago, Ill.

10

Index

July 17, 1937 Holy Redeemer Cam.

Chicago, Ill.

G. Francis Schupp 3715 Frederick Ave, Chicago, Ill.

July 17, 1937

## CERTIFICATE OF DEATH

09281

09285

|  |                               |   |  |   |   |   |  |
|--|-------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                               | c. LENGTH OF STAY IN 1b<br><b>1 hour</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>                                       |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Towson, Y.M.C.A.</b>  |                               |   |  | d. STREET ADDRESS<br><b>909 Southerly Rd.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Jessie Sherman Penhallegon</b>   |                               |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>20</b> Year <b>67</b>  |   |   |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 20, 1893</b> |   | 9. AGE (In years last birthday) yrs.<br><b>73</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Baptist Book Publishing Co.</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ill.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Milton A. Sherman</b>  |                               |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Goodrich</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                               | 16. SOCIAL SECURITY NO.<br><b>349 26 6176</b>   |  | 17. INFORMANT<br><b>J.S. Penhallegon, 2220 <del>####</del> Foxley Rd.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>ARTERIOSCLEROTIC HEART DISEASE</b><br>4200<br>IMMEDIATE CAUSE (a) DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |                               |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>OCT</b> , 19 <b>63</b> , to <b>JUL 20</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>JUL 7</b> , 19 <b>67</b> , and that death occurred on <b>3P</b> M, from causes and on the date stated above.             |                               |   |  |   |   |   |  |
| 22a. SIGNATURE<br><b>T. C. Siwinski</b>  |                               |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>    |   | 22b. DATE SIGNED<br><b>July 21, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Thaddeus C. Siwinski</b>  |                               |   |  | 22d. ADDRESS<br><b>206 W. Pennsylvania Ave, Towson, Md.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                               | 23b. DATE THEREOF<br><b>7-24-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Evanston Ill.</b>                             |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md.</b>   |                               |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 24 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2200

4230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09296

CERTIFICATE OF DEATH

09295

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>                 |  | b. COUNTY<br><b>Baltimore</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  | c. LENGTH OF STAY IN 1b<br><b>7</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>534 Hampton Lane</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>EDWARD W. PINEAU</b>   |  | 4. DATE OF DEATH<br><b>July 1, 1967</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Cau.</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>August 5, 1910</b>   |  | 9. AGE (In years lost birthday)<br><b>56 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Roofers, Inc.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Leonard Pineau</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Kenneth</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>[REDACTED]</b>   |  | 17. INFORMANT<br><b>Mrs. Lillian Pineau, Same as # 2</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO (b) <b>Coronary artery disease &amp; failure</b><br>DUE TO (c) <b>Hypertensive C.V. disease</b>               |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 yrs</b><br><b>15 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Ankylosing spondylitis with cardiac insufficiency</b>   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>ot work ot work                            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)  |  | 20g. (City or town) (County) (State)   |  | 20h. (City or town) (County) (State)  |  |
| 21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>Dec. 21, 1959</b> , to <b>June 2, 1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>June 2, 1967</b> , and that death occurred at <b>7 P.M.</b> from causes on and the date stated above. |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Harry F. Klinefeater</b>   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>H. F. KLINEFEATER</b>  |  | 22d. ADDRESS<br><b>550 N. BROADWAY, BALTO, 21205</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>July 4, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Maryland</b>  |  | 23e. LOCATION (City or Town) (County) (State)  |  | 23f. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 6 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

RECEIVED

1937

Director

Room 1

St. Louis, Mo.

St. Louis, Mo.

1937

Jan. 1, 1937

Jan. 1, 1937

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St. Louis, Mo.

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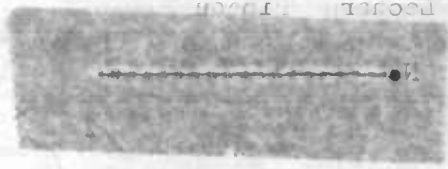
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |  |  |   |  |
|--|--|--|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |  |  |   |  |
| 09297  |  |  |  |   | 09296   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN lb<br><b>10 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>   |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b><br>d. STREET ADDRESS<br><b>4217 Ivanhoe Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Agnes Irene Price</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>7-16-1967</b>  |  |  |   |  |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>April 28, 1892</b>                              |  | 9. AGE (In years last birthday)<br><b>75 yrs.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Texas, Maryland</b>   |   |  | 12. CITIZEN OF WHAT COUNTRY?                     |   |  |
| 13. FATHER'S NAME<br><b>George F. Price</b>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Rose Barrett</b>   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>Address<br><b>Frank B. Price, Sr. 4217 Ivanhoe Ave.</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO<br><b>4201</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |   |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |  |   |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 15</b> , 19 <b>67</b> , to <b>July 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 16</b> , 19 <b>67</b> , and that death occurred at <b>4:10AM</b> , from causes and on the date stated above.  |  |  |  |   |   |  |  |   |  |
| 22a. SIGNATURE<br><b>[Signature]</b> M.D.  |  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>July 16, 1967</b>         |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ismael Jamora</b>   |  |  |  |   | 22d. ADDRESS<br><b>7620 York Rd., Baltimore Co., Md. 21212</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/19/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial Gardens</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>John A. Moran, Inc. 3000 E. Baltimore St.</b>  |  |  |  |   | 25a. REG'D BY REGISTRAR<br>DATE<br><b>JUL 18 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |   |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Baltimore</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2627 Windsor Road</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b><br>d. STREET ADDRESS <b>2627 Windsor Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>MABEL E. PRICE</b>  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>24</b> Year <b>1967</b>   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>Nov. 17, 1908.</b><br>9. AGE (In years last birthday) <b>58</b> yrs.             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
| 13. FATHER'S NAME <b>William McKinley</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Kelly</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <b>218-28-4510</b>   | 17. INFORMANT <b>Mr. John W. Price, Sr.</b> Address <b>(Same)</b>                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ |   |  | INTERVAL BETWEEN ONSET AND DEATH _____   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19 _____   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   | 20f. (City or town) _____ (County) _____ (State) _____   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>            |   |  |  |
| ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b><br>EXAMINER'S NAME (Type)   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) _____   |  |
| 22. DATE SIGNED <b>7/24/67</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>7/27/67.</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>   | 23d. LOCATION (City or Town) <b>Baltimore, Md.</b> (County) _____ (State) _____                      |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b><br>ADDRESS   |   | 25a. REC'D BY REGISTRAR <b>JUL 25 1967</b>   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>11yr7mth2dys</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen, Maryland</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |  |   | d. STREET ADDRESS<br><b>2 Aberdeen Avenue</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Maude</b> Middle <b>Smith</b> Last <b>Proctor</b>  |  |   | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>24</b> Year <b>1967</b>   |   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 1, 1889</b>   |   | 9. AGE (In years last birthday) yrs. <b>82</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Nova Scotia</b>                                     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |   | 13. FATHER'S NAME<br><b>John</b>   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Ellen Kilcop</b>   |  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)                                 |   |   |
| 16. SOCIAL SECURITY NO.<br><b>022-18-5098</b>   |  | 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction,</b><br>DUE TO (b) <b>Arteriosclerotic Cardiovascular Heart Disease</b><br>DUE TO (c) <b>Arteriosclerosis, generalized, senile</b>    |  |   |  |   | INTERVAL BETWEEN LONGEST AND DEATH<br><b>1 day</b><br><b>20 years</b><br><b>20 years</b>          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.<br><b>Pneumonia, bilateral, bronchial, organism unk.; uremia &amp; arterioneuro-</b>   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o.m.</b> <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |   |   |
| 21. I certify that <b>she</b> (this <b>hospital</b> ) attended the deceased from <b>Dec. 22, 1955</b> to <b>July 24, 1967</b> , that <b>she</b> (we) last saw the deceased alive on <b>July 24, 1967</b> , and that death occurred at <b>8:35P</b> M, from causes and on the date stated above. |  |   |  |   |   |
| 22a. SIGNATURE<br><br>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |   | 22b. DATE SIGNED<br><b>July 24, 1967</b>   |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.B.</b>   |  |   | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/27/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Wollaston Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Quincy, Mass.</b>   |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.</b>  |  |   | 25a. REC'D BY REGISTRAR<br><b>ME JUL 27 1967</b>   |   |   |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br>   |   |   |

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                     |  |   |  |  |  |  |  |   |  |
|---|--|-------------------------------------|--|---|--|--|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                     |  |   |  |  |  |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b> MARYLAND   |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  |                                     |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b>                     |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>   |  |                                     |  |   |  | d. STREET ADDRESS<br><b>710 Evesham Avenue</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>(FEMALE) Dawn Marie PTAK</b>   |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>7 2 19 67</b>   |  |  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Cau.</b>     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6/30/67</b>   |  | 9. AGE (In years lost birthday) yrs.<br><b>3</b>                       |  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>3</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Francis Louis Ptak</b>  |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Vasquez</b>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Mr. Francis L. Ptak</b> Address<br><b>(Same)</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7730</b> IMMEDIATE CAUSE (a)<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c)<br><b>Digitalis toxicity</b>   |  |                                     |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 HRS.</b>  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.<br><b>Spleen Membranous Disease</b>  |  |                                     |  |   |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                     |  |   |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Digitalis intoxication during rapid digitalization</b>   |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>8:30</b> Hour a.m. <b>July 2 1967</b>  |  |                                     |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Hospital</b>                                      |  | 20f. (City or town) (County) (State)<br><b>Baltimore</b>               |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.<br>EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b><br>22. DATE SIGNED <b>7/3/67</b> |  |                                     |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>7/5/67.</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  |                                     |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 5 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |  |   |  |

11111

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial, cremation or removal.

1. NAME OF DECEASED  
(Type or Print)

Marie Purcochar

2. DATE AND HOUR OF DEATH

7/30/67

3. PLACE OF DEATH IN BALTIMORE-MARYLAND

BALTIMORE COUNTY  
(If not in hospital or institution, give street address or location)3402 Essex Rd  
Baltimore, Md 21207

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3402 Essex Rd

5. SEX

Female

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

Aug 15, 1882

9. AGE (In years  
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Czech

12. CITIZEN OF  
WHAT COUNTRY?

Usa

13. FATHER'S NAME

Unk

14. MOTHER'S MAIDEN NAME

Unk

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Septicemic Shock secondary  
to septic cystitis & decubitus  
ulcers

DUE TO

(B) Acute cystitis

DUE TO

(C) Decubitus ulcersINTERVAL BETWEEN  
ONSET AND DEATH

5 days

1 mo

5 mo

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING ITHypertensive arterio-  
sclerotic heart disease

22. I certify that (I) (this hospital) attended the deceased from

1963

to

July 25, 1967

that (I) (we) last saw the deceased alive on

1967

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James Colohan

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

7/31/67

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/2/67

24C. NAME OF CEMETERY or CREMATORY

Holy Cross Cem

24D. LOCATION

A A Co

(City, town, or county)

(State)

Md

ADDRESS

VR A15 (4)  
25M 1/67

25A. DATE REC'D BY HEALTH DEPT

AUG 7 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

McCallister FH 227 Baltimore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1 (M)

09302

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

09301

|   |                                  |  |  |   |   |   |   |
|---|----------------------------------|--|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randallstown</u>   |                                  | c. LENGTH OF STAY IN lb<br><u>1 day</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randallstown</u>                                 |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Baltimore County General</u>   |                                  |  |  | d. STREET ADDRESS<br><u>5007 Green Lane</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Leah</u> Middle <u>R.</u> Last <u>Randall</u>   |                                  |  |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>19</u> Year <u>1967</u>  |   |   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>Aug. 18, 1903</u> | 9. AGE (In years last birthday)<br><u>63</u> yrs.   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |   | 11. IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>PENNA.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>George Brodbeck</u>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Kathryn Raffenberg</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>-</u>  |  | 17. INFORMANT<br>Address <u>Mr. Charles Randall - Randallstown, Md.</u>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrhythmia - 3</u><br>DUE TO (b) <u>Coronary Thrombosis - Myocardial infarct</u><br>DUE TO (c) <u>CORONARY Heart disease, severe</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>terminal</u><br><u>3 mo</u><br><u>3 mo</u>                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1967</u> to <u>July 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1967</u> , and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above.  |                                  |  |  |   |   |   |   |
| 22a. SIGNATURE<br><u>Simeon Calle</u>   |                                  |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>    |   | 22b. DATE SIGNED<br><u>7-19-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Simeon Calle</u>   |                                  |  |  | 22d. ADDRESS<br><u>Balto. County Gen. Hospital</u>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 23b. DATE THEREOF<br><u>7-22-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Stone Chapel Cemetery</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Brodbecks PA.</u>                             |   |
| 24. FUNERAL DIRECTOR<br><u>Harry W. Haight</u>  |                                  |  |  | ADDRESS<br><u>Lysacville, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 24 1967</u>  |   |
|   |                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. J...</u>  |   |   |   |

9450



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                           |   |   |  |  |   |  |  |
|--|--|---------------------------|---|---|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |   |   |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |                           |   |   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>c. LENGTH OF STAY IN 1b<br><b>Baltimore</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1636 Hardwick Rd.</b>   |  |                           |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>1636 Hardwick Rd.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Frederick P. Rappe</b>  |  |                           | First Middle Last   |   | 4. DATE OF DEATH <b>July 23</b>  |  | Day Year <b>19 67</b>   |  |  |
| 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Dec 16, 1915</b>                                     |   | 9. AGE (In years last birthday) <b>51</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>   |  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md.</b> |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <b>Henry</b>   |  |                           |   |   | 14. MOTHER'S MAIDEN NAME <b>Roberts</b>  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>   |  |                           | 16. SOCIAL SECURITY NO. <b>2nd W.W. 213-05-4151</b>   |   | 17. INFORMANT <b>Wife</b>  |  | Address <b>Same</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b><br><b>443</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                           |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                           |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                              |  |  |
| 21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>March, 1967</b> , to <b>July, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>2 July 1967</b> , and that death occurred at <b>11:25 P.M.</b> from the causes and on the date stated above.   |  |                           |   |   |  |  |   |  |  |
| 22a. SIGNATURE <b>Wm. H. Kammer Jr.</b>  |  |                           |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED <b>24 July 1967</b>                              |  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |                           |   |   | 22d. ADDRESS   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                           | 23b. DATE THEREOF <b>7/26/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat.</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b> |  |  |
| 24. FUNERAL DIRECTOR <b>P.A. Heemann</b>   |  |                           |   |   | ADDRESS <b>6067 Harford Rd.</b>  |  | 25a. REG. BY REGISTRAR <b>28 1967</b><br>DATE <b>28 1967</b>      |  |  |

022303

0002

3-11-1918

MA.

Baltimore

Baltimore

1918 Baltimore Md.

1918 Baltimore Md.

Frederick A. Brown

July 23

Dec 10, 1918

Charles Baker

Baltimore

Henry

Roberts

les

2nd W. 113-05-1151

Bans

W-6-81

Baltimore Md.

Baltimore Md.

W.A. Lamm

1918

CERTIFICATE OF DEATH

09304

09303

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                     |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Pikesville</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 yrs.</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>1728 Reisterstown Road, Pikesville, Md.</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nathan</b> Middle <b>Albert</b> Last <b>Rock</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>15</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 24, 1886</b>  |  |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bendix</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>John Rock</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura Haulman</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>217-01-4920</b>   |  | 17. INFORMANT<br>Address <b>Pikesville 6, Md.</b><br><b>Mrs. Kathleen Seal, 1728 Reisterstown Rd.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4200 arteriosclerotic heart disease</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Few years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>July 15, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>14 July 1967</b> , and that death occurred at <b>8:18 PM</b> , from the causes and on the date stated above.                          |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Paul H. Royse</b> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>July 15, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul H. Royse</b>   |  |   |  | 22d. ADDRESS<br><b>1403 Foley Lane Pikesville Md</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>July 16, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Towson, Md.</b>                                    |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Frank H. Newell, Pikesville, Md.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 19 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

00000

MEMORANDUM

TO : DIRECTOR, FBI

FROM : SAC, [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 09305  |                                  | 09304  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson 4</b><br>c. LENGTH OF STAY IN Tb<br><b>4</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>Box 296, Ridge Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Clara E. Royahn</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>22</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>June 13, 1930</b> |
| 9. AGE (In years last birthday)<br><b>37</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>13</b> Days <b>09</b> Hours <b>00</b> Min. <b>00</b>  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 12. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore County</b>   |                                  | 14. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 15. FATHER'S NAME<br><b>Calvin Shaffer</b>   |                                  | 16. MOTHER'S MAIDEN NAME<br><b>Mary Elizabeth Johnson</b>  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                                  | 18. SOCIAL SECURITY NO.<br><b>216-46-1860</b>  |  |
| 19. INFORMANT<br><b>Mr. William B. Stansbury Jr.</b>   |                                  | 20. ADDRESS<br><b>Trust Bldg 403 Mercantile</b>  |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4341</b><br>IMMEDIATE CAUSE (a) <b>Pulmonary thromboembolism</b><br>DUE TO <b>congestive heart failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Acute fibrinopurulent pericarditis</b>   |                                  | 23. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 26. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                                  | 27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 28. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                                  | 29. (City or town) (County) (State)  |  |
| 30. I certify that (a) (the hospital) attended the deceased from <b>July 13, 19 67</b> , to <b>July 22, 19 67</b> that (b) (we) last saw the deceased alive on <b>July 22, 19 67</b> , and that death occurred at <b>1 p.m.</b> from causes and on the date stated above.  |                                  |  |  |
| 31. SIGNATURE<br><b>Reynaldo Orjuela-Gomez, M. D.</b>  |                                  | 32. DATE SIGNED<br><b>July 22, 1967</b>  |  |
| 33. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M. D.</b>  |                                  | 34. ADDRESS<br><b>7620 York Road, Towson 4, Md.</b>  |  |
| 35. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 36. DATE THEREOF<br><b>7-25-1967</b>   |  |
| 37. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                                  | 38. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>   |  |
| 39. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>  |                                  | 40. ADDRESS<br><b>7401 Belair Road</b>   |  |
| 41. REC'D BY REGISTRAR<br><b>DATE JUL 25 1967</b>  |                                  | 42. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

REPORT OF THE COMMISSIONER

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09305

FOR STATE  
HEALTH DEPT.

09306

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|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH'S HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>3031 CALIFORNIA AVE.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>JAMES</b> First Middle Last  |   | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>22</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-29-23</b>   |
| 9. AGE (In years last birthday) yrs. <b>44</b>   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHARLES KEARNEY</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>JOHN RUBY</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>HANNA LYNCH</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>WW 2</b>   |   | 16. SOCIAL SECURITY NO.<br><b>215-12-5780</b>  |  |
| 17. INFORMANT<br><b>ELWOOD RAWLINGS</b> Address <b>8325 ELLEN AVE.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE<br><b>Francis X. Carmody</b>  |   | 22. DATE SIGNED<br><b>7-22-67</b>  |  |
| EXAMINER'S NAME (Type)<br><b>FRANCIS X. CARMODY, M.D.</b>  |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/27/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 25 1967</b>  |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAMES

Q08Y

unrecorded information

Don K. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09306

09307

CERTIFICATE OF DEATH

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>1 Month</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b>  |                                  | d. STREET ADDRESS<br><b>501 Castle Drive</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Clara</b> Middle <b>L.</b> Last <b>SCHAEFER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>5</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>October 6, 1882</b> |
| 9. AGE (In years last birthday) yrs.<br><b>84</b>   |                                  | IF UNDER 1 YEAR<br>Months <b>03</b> Days <b>1</b> Hours <b>00</b> Min. <b>00</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>William Shower</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ross</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-46-3648</b>  |  |
| 17. INFORMANT<br><b>Mr. Wm. F. Schaefer</b>   |                                  | Address<br><b>602 St. Francis Rd.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Occlusion of right coronary artery</b><br>DUE TO<br>(c) <b>Generalized arteriosclerosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Status post colectomy</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>June 1, 1967</b> to <b>July 5, 19 67</b> , that <del>(X)</del> (we) lost the deceased alive on <b>July 5, 19 67</b> , and that death occurred at <b>2:05 PM</b> , from causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>Cockburn</b>   |                                  | 22b. DATE SIGNED<br><b>July 6, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>M.S. Cockburn, M.D.</b>  |                                  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |
| 23a. BURIAL CREMATION, REMOVAL, or other disposition<br><b>Entombed</b>   |                                  | 23b. DATE THEREOF<br><b>7/8/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorriane Park Mausoleum</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1967</b>  |  |
| ADDRESS<br><b>1050 York Rd. 21204</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>   |  |

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## CERTIFICATE OF DEATH

09303

09307

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b><br>c. LENGTH OF STAY IN 1b<br><b>MIDDLE RIVER</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>                    |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>MIDDLE RIVER</b><br>d. STREET ADDRESS<br><b>1416 Third Road #21220</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>William B. Schratz</b>  |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>30</b> Year <b>1967</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 12, 1900</b>  | 9. AGE (In years last birthday)<br><b>66</b> yrs.                            | 10. IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>18</b> Hours <b>00</b> Min.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INDUSTRY</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Glenn L. Martin Co.</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York, N.Y.</b> |   |
| 13. FATHER'S NAME<br><b>JOHN SCHRATZ</b>   |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>UNIC</b>   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>BARBARA OBERHOFFER</b>   |  |   |
| 16. SOCIAL SECURITY NO.<br><b>109-05-0872</b>  |   |   | 17. INFORMANT<br><b>FRANCES SCHRATZ</b> Address <b>ABOVE</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thrombosis left coronary artery</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>2201  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Uremia secondary to chronic pyelonephritis.</b>   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 5, 1967</b> , to <b>July 30, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 30, 1967</b> , and that death occurred at <b>11:20 PM</b> from causes and on the date stated above. |   |   |   |  |   |
| 22a. SIGNATURE<br><b>October 1967</b>  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  | 22b. DATE SIGNED<br><b>July 31, 1967</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>M.S. Cockburn, M.D.</b>   |   |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>AUG. 3, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>  |  |   |
| 24. FUNERAL DIRECTOR<br><b>J.E. CONNELLY SONS</b>  |   |   | 25a. REC'D BY REGISTRAR<br><b>3 AUG 1967</b>  |  |   |
| ADDRESS<br><b>300 MACE</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>  |  |   |

STATEMENT OF DEBIT

1900

For the year ending December 31, 1900

By the Director of the Bureau of the Census

For the year ending December 31, 1900

For the year ending December 31, 1900

For the year ending December 31, 1900

For the year ending December 31, 1900

For the year ending December 31, 1900

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For the year ending December 31, 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09308

CERTIFICATE OF DEATH

09308

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>  |   | c. LENGTH OF STAY IN 1b<br><b>30.4</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MILFORD MANOR NURSING HOME</b>   |   | d. STREET ADDRESS<br><b>3903 BARRINGTON ROAD</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>LENA SCHULTZ</b>  |   | 4. DATE OF DEATH <b>JULY 7, 19 67</b>   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>86</b> yrs.  |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.   |   | 10. IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>LITHUANIA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>LEPA BLUMBERG</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>MOTLA ?</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.<br><b>NO</b>  |   |
| 17. INFORMANT<br><b>MR. DAVID SCHULTZ, 5511 GIST AVENUE #15</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis C.V.D. &amp; Hypertension</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>12 yrs.</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-3-</b> , 19 <b>64</b> , to <b>7-7-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-7-</b> 19 <b>67</b> , and that death occurred at <b>3:30</b> M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>DR. HARVEY FUERERMAN</b>   |   | 22b. DATE SIGNED<br><b>7/7/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. HARVEY FUERERMAN</b>   |   | 22d. ADDRESS<br><b>6210 PARK HEIGHTS AVENUE</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>7/7/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 14 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

22388

BALTIMORE

BALTIMORE

WILLIAM WADSWORTH WADSWORTH

JOHN WADSWORTH WADSWORTH

LEWIS

SCHULTZ

JOHN WADSWORTH

WILLIAM WADSWORTH

AT HOME

AT HOME

WILLIAM WADSWORTH

WILLIAM WADSWORTH

MR. WADSWORTH, 2211 FIRST AVENUE

MR. WADSWORTH, 2211 FIRST AVENUE

MR. WADSWORTH, 2211 FIRST AVENUE

BALTIMORE

BALTIMORE

JUL 1 1927

WILLIAM WADSWORTH, 2211 FIRST AVENUE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09309

09310

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN TB<br><b>103.1</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Balto</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore #21206</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>  |                                  | d. STREET ADDRESS<br><b>106 E. Elm Avenue</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Thelma M. Schultz</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>4</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>February 1, 1912</b> |
| 9. AGE (In years lost birthday)<br><b>55 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>19</b> Hours <b>67</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Schuylkill Haven, Penna.</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Reed</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Hattie Wood Bolton</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   |
| 17. INFORMANT<br><b>Norman W. Schultz</b>   |                                  | Address<br><b>same</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent myocardial infarction</b><br>DUE TO<br>4201<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH     |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (o)<br><b>Arteriosclerotic cardiovascular disease.</b>  |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o.m.</b> Month, Day, Year <b>19</b><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 24</b> , 19 <b>67</b> , to <b>July 4</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 4</b> , 19 <b>67</b> , and that death occurred at <b>6:05 A.M.</b> , from causes and on the date stated above. |                                  |  |   |
| 22a. SIGNATURE<br><b>Reynaldo Orjuela-Gomez</b>   |                                  | 22b. DATE SIGNED<br><b>July 4, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M.D.</b>   |                                  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/7/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Park Cem.</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Balto. Md.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 5 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |  |   |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

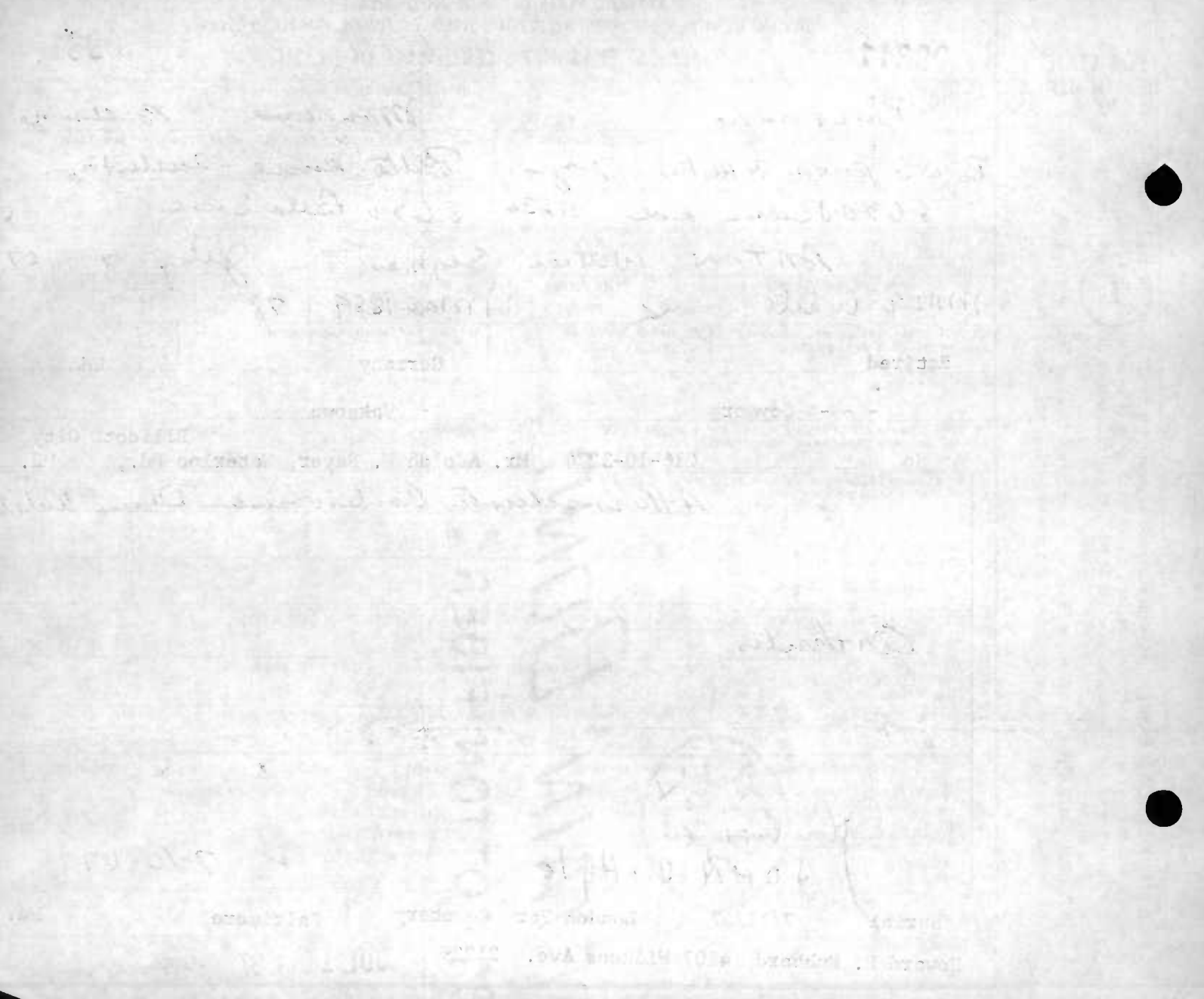
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09311

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09310

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO RURAL Fullerton</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto-Rural-Fullerton 13-1</u>                                       |                                    |
| c. LENGTH OF STAY IN 1b <u>2 yrs.</u>  |                               | d. STREET ADDRESS <u>8620 Belair Rd</u>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8620 Belair Rd 21236</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED (Type or print) <u>ANTON William Seymour</u>   |                               | 4. DATE OF DEATH <u>July 7 1967</u>  |                                    |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1 Mar 1889</u> |
| 9. AGE (In years, months, and days) <u>78</u>  |                               | 10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u> Hours <u>1</u> Min. <u>0</u>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                    |
| 13. FATHER'S NAME <u>- - - Seymour</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>216-10-3274</u>   |                                    |
| 17. INFORMANT <u>Mr. Adolph W. Seyer, Waterloo Rd., Md.</u>  |                               | Address <u>Ellicott City, Md.</u>  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO <u>4221</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arthritis</u><br>DUE TO (c)  |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis</u>   |                               |  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u><br>p.m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                               |  |                                    |
| ACTUAL SIGNATURE <u>John C. Hyle</u>   |                               | 22. DATE SIGNED <u>7-10-67</u>   |                                    |
| EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>   |                               | Address (Street, city, town, or county)  |                                    |
| 23a. BURIAL CREMATION REMOVAL <u>Burial</u>  |                               | 23b. DATE THEREOF <u>7/11/67</u>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>   |                               | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>   |                                    |
| 24. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>  |                               | 25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>   |                                    |
| ADDRESS <u>4107 Wilkens Ave. 21229</u>   |                               | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>  |                                    |





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |
| c. LENGTH OF STAY IN 1b   |  | d. STREET ADDRESS <u>2108 Northcliff Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine Ridge Golf Course, Dulaney Valley Rd.</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Albert Memie Shaivitz</u>  |  | 4. DATE OF DEATH <u>July 30, 1967</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     | 8. DATE OF BIRTH <u>May 11, 1915</u>                                     |
| 9. AGE (In years lost birthday) <u>52</u> yrs.  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacture Rep.</u>                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>                       |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Samuel Shaivitz</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Stella Kaplan</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |  |
| 17. INFORMANT <u>Mrs. Blanche Shaivitz, 2108 Northcliff Drive</u>   |  | Address <u>#9</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion Sudden</u><br>DUE TO (b) <u>Coronary Insufficiency</u><br>DUE TO (c) <u>2+ yrs.</u>  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.   |  | 22. DATE SIGNED <u>7/30/67</u>   |  |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>7/31/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>   |  | 25a. REC'D BY REGISTRAR <u>AUG 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Joyce</u>   |  |

51035

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09312

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09312

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  | c. LENGTH OF STAY IN 1b<br><b>30.4</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |  | d. STREET ADDRESS<br><b>419 Charter Oak Ave.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Dr. Harold J. Shea</b>  |  | 4. DATE OF DEATH<br>7 Month 4 Day Year <b>67</b>  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>4-26-97</b>            |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Pharmacist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dickman's Phar.</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>James W. Shae</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna A. Kelly</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWI</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212-07-8304A</b>  |   |
| 17. INFORMANT<br><b>Mrs. Velma L. Shea</b>  |  | Address<br><b>(Same)</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>260X Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b><br>(c) <b>Diabetes Mellitus</b>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>10+ yrs</b><br><b>10+ yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)          |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell, M.D.</b>   |  | 22. DATE SIGNED<br><b>7/4/67</b>  |   |
| EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>  |  | Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State) |
| <b>Burial</b>   | <b>7/8/1967</b>  | <b>Dulaney Valley Mem. Grds.</b>  | <b>Timonium, Balto. Co. Md.</b>               |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 5 1967</b>  |   |
| Address<br><b>4905 York Road Balto. 12, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jager</b>   |   |

1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09314

## CERTIFICATE OF DEATH

09313

|  |                                  |   |  |  |  |  |  |
|--|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randallstown</u>  |                                  |   | c. LENGTH OF STAY IN 1b<br><u>2 mos 11 days</u>    |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> <u>03-1</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Baltimore County General Hosp</u>   |                                  |   |  | d. STREET ADDRESS<br><u>3330 Essex Rd</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Leo N.M.N. Sidlin</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>9</u> Year <u>1967</u>  |  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-15-07</u>                 |  | 9. AGE (In years last birthday)<br><u>60</u> yrs.                    |  | 10. UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETAIL</u>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>RETAIL</u> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>RUSSIA</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |
| 13. FATHER'S NAME<br><u>MERCHANT MENDEL SIDLIN</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>CHANA</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>212-26-8822</u>   |  | 17. INFORMANT<br><u>Hospital chart</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO (b) <u>Chronic Renal disease</u><br>DUE TO (c) <u>Chronic Pyelonephritis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>month</u>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hypertension</u>   |                                  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/28/67</u> , to <u>7/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> , 19 <u>67</u> , and that death occurred at <u>4:54</u> M, from causes and on the date stated above.   |                                  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>[Signature]</u>   |                                  |   |  | 22b. DATE SIGNED   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>D. A. E. SUBONG JR</u>  |  |
| 22d. ADDRESS<br><u>Baltimore County Gen. Hosp</u>  |                                  |   |  | 22e. MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                         |  | 22f. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 23b. DATE THEREOF<br><u>7/10/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MOSES MONTIFILORE</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE, MD.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>JUL 12 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

STATE OF TEXAS

1934

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

Witness my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1934.

DEPUTY

CLERK OF THE COUNTY OF DALLAS, TEXAS

WITNESSETH MY HAND AND SEAL

THIS 1st DAY OF JANUARY, 1934

AT DALLAS, TEXAS

1934-01-01

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

Witness my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1934.

DEPUTY CLERK OF THE COUNTY OF DALLAS, TEXAS

WITNESSETH MY HAND AND SEAL THIS 1st DAY OF JANUARY, 1934 AT DALLAS, TEXAS

1934-01-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |  |   |   |   |   |  |
|--|--|---|--|--|---|---|---|---|--|
| Item #7 Film G392 8/24/67 hr   |  |   |  |  |   |   |   |   |  |
| 09314  |  |   |  |  |   |   |   |   |  |
| CERTIFICATE OF DEATH   |  |   |  |  |   |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b><br>c. LENGTH OF STAY IN 1b <b>76 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FOXLEIGH NURSING HOME</b>   |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b><br>d. STREET ADDRESS <b>5432 NARCISSIS AVE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JACOB</b> Middle <b>SYWERBERG</b> Last <b>SYWERBERG</b>  |  |   |  |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>29</b> Year <b>19 67</b>  |   |   |   |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 8. DATE OF BIRTH <b>6/11/81</b>                                   |   | 9. AGE (In years last birthday) <b>86</b> yrs.                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                           |  |
| 13. FATHER'S NAME <b>SHOLOM</b>  |  |   |  |  | 14. MOTHER'S MAIDEN NAME <b>TOBY</b>  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>210-32-2495</b>   |   | 17. INFORMANT <b>MR. ALLEN B. SPECTOR</b>                         |   | Address <b>10 SOUTH STREET</b>                                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>4201<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Disease Chronic G.C. infection</b> |  |   |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>unknown</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                              |   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-24</b> , 19 <b>67</b> , to <b>7-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-27</b> , 19 <b>67</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above.  |  |   |  |  |   |   |   |   |  |
| 22a. SIGNATURE <b>David J. Miller</b>  |  |   |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22b. DATE SIGNED <b>7-29-67</b>                   |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>David J. Miller</b>  |  |   |  |  | 22d. ADDRESS <b>Lisbon Rd - Owings Mills, Md</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>7/30/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Run</b>  |   | 23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>  |   |   |  |
| 24. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc</b>   |  |   |  |  | ADDRESS <b>Garrison Md</b>  |   | 25a. REC'D BY REGISTRAR <b>AUG 1 1967</b>         |   |  |
|  |  |   |  |  |   |   | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b> |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 23b, 23c, Film 6392 8/24/67 kk

CERTIFICATE OF DEATH

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Baltimore</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>Alleghany</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>17yr11mth18dys</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland, Maryland</b>  |                                  | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |  |
| d. STREET ADDRESS<br><b>2 Bedford Road</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Clara</b> Middle <b>Belle</b> Last <b>Simmons</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>26</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Jan. 31, 1897</b> |
| 9. AGE (In years and birth day)<br><b>69</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>factory</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |
| 13. FATHER'S NAME<br><b>Albert D. Shields</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Williams</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>unknown</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>215-14-6278</b>  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic cardiovascular disease</b> |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1</b> , 19 <b>68</b> to <b>July 26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 26</b> , 19 <b>67</b> , and that death occurred at <b>3:10</b> M, from causes and on the date stated above.  |                                  |  |  |
| 22a. SIGNATURE<br><b>Stella Wachsler</b>   |                                  | 22b. DATE SIGNED<br><b>7-26-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachsler, M.D.</b>   |                                  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>8-22-67</b>  |                                  | 23b. DATE THEREOF  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomy Board of Maryland</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 28 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |  |  |

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10/25/1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |   |   |   |   |  |  |  |
|---|--|-------------------------------|---|---|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |   |   |   |   |  |  |  |
| 09317 CERTIFICATE OF DEATH 09316  |  |                               |   |   |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8609 Dovedale Road</b>  |  |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Balto.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b><br>d. STREET ADDRESS <b>8609 Dovedale Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Betty</b> Middle <b>Mae</b> Last <b>Smith</b>   |  |                               |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>16</b> Year <b>19 67</b>   |   |  |  |  |
| 5. SEX <b>FEMALE</b><br><b>Male</b>   |  | 6. COLOR OR RACE <b>Cauc.</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>May 10, 1950</b> |  | 9. AGE (In years last birthday) <b>17</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>   |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John P. Smith</b>   |  |                               |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Edna Thompson</b>  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |                               | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>John P. Smith 8609 Dovedale Rd. Randallstown</b>  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Viral Encephalitis</b><br><b>0823</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) OUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                               |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)               |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1967</b> , to <b>July 16, 1967</b> , that (II) (we) last saw the deceased alive on <b>July 15, 1967</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.   |  |                               |   |   |   |   |  |  |  |
| 22a. SIGNATURE<br><b>John J. Darrell</b>  |  |                               |   |   |   |   |  | 22b. DATE SIGNED<br><b>7/17/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>John J. Darrell, M.D.</b>   |  |                               |   |   | 22d. ADDRESS<br><b>9017 Liberty Rd. Randallstown, Md</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |                               | 23b. DATE THEREOF<br><b>7/19/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cokesbury Memorial Meth.</b>   |   |  | 23d. LOCATION (City, town or county) (State)<br><b>Harford Co. Md.</b>                   |  |
| 24. FUNERAL DIRECTOR  |  |                               | ADDRESS<br><b>Ullrich Funeral Home 4210 Belair Rd. Balto</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JUL 20 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |  |

Baltimore

Handwritten

8000 Riverside Road

Barry

June

Student

John P. Smith

Handwritten

Handwritten

800 Riverside Road

Barry

June 10, 1960

Handwritten

John P. Smith

Baltimore

July 10

12

Handwritten

Cornelius Memorial Beth.

1960

Ulrich Funeral Home 4510 Belair Rd. Balto

Harford Co.

1960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

09318

09317

|  |  |  |  |   |  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u><br>c. LENGTH OF STAY IN b. <u>5 1/2 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>     |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u><br>d. STREET ADDRESS <u>1737 Joan Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Edward J. Smith</u>   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>7</u> Day <u>31</u> Year <u>1967</u>  |  |  |  |  |  |   |  |  |  |   |  |
| <b>5. SEX</b><br><u>M</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>B. DATE OF BIRTH</b><br><u>2/21/83</u>  |  | <b>9. AGE (In years last birthday)</b><br><u>84</u> yrs.                           |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>                           |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>  </u>   |  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Baltimore, Md</u> |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |  |   |  |
| <b>13. FATHER'S NAME</b><br><u>Peter Smith</u>   |  |  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Margaret PEIS</u>  |  |  |  |   |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><u>unknown</u>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>216-16-6811</u>  |  |  |  | <b>17. INFORMANT</b><br><u>Hospice records</u>                                     |  |   |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca hung - infarct</u><br>1621 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Ca hung Prim</u><br>(a), stating the underlying cause last. DUE TO (c) <u>Asphy</u> |  |  |  |   |  |  |  |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>  </u>   |  |   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b><br><u>  </u>   |  |  |  |   |  |  |  |  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |  |  |  |  |  |   |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |  | <b>20f. (City or town)</b><br><u>  </u>  |  | <b>(County)</b><br><u>  </u>   |  | <b>(State)</b><br><u>  </u>   |  |  |  |   |  |
| <b>21. I certify that (I) (This hospital) attended the deceased from <u>11/10/61</u>, 19<u>  </u>, to <u>7/31/67</u>, 19<u>  </u>, that (I) (we) last saw the deceased alive on <u>7/30/67</u>, 19<u>  </u>, and that death occurred <u>12:05A</u> from the causes and on the date stated above.</b>                                 |  |  |  |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Robert J. Mahon</u> M.D.   |  |  |  |   |  | <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b><br><u>204 E. Joppa Rd., Towson</u> |  |  |  | <b>22b. DATE SIGNED</b><br><u>7/31/67</u>   |  |  |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Robert Mahon, M. D.</u>  |  |  |  |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  |  |  | <b>23b. DATE THEREOF</b><br><u>8-2-67</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Moreland Memorial</u>  |  |  |  | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Parkville, Balto. Md.</u> |  |  |  |   |  |
| <b>24 FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Wm. Cook-Brooks</u>   |  |  |  |   |  | <b>ADDRESS</b><br><u>Towson, Towson, Md.</u>   |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>AUG 2 1967</u>                                 |  |  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u> |  |

8420

09319

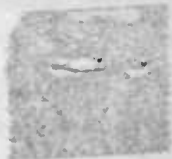
CERTIFICATE OF DEATH

09318

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|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jessup</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Greater Baltimore Medical Ctr</b>  |  | d. STREET ADDRESS<br><b>51 Montevideo Court</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Albert</b> Last <b>Smith Jr.</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>13</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Can</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-14-15</b>  |
| 9. AGE (In years lost birthday)<br><b>52</b> yrs.   |  | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Manager</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Delivery Service</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Knoxville, Tenn.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William Albert Smith Sr.</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Taylor (Bessie)</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>409-18-4801</b>   |   |
| 17. INFORMANT<br><b>Mrs. Margaret V. Smith</b>  |  | Address<br><b>+ Patients Chart.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br>163X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTASES FROM CA, LUNG</b><br>DUE TO<br>(c) <b>RECURRENT CARCINOMA, LUNG</b> |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>SPINAL CORD COMPRESSION; BRONCHOPNEUMONIA</b>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>NO</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. — p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-13-67</b> , 19 <b>67</b> to <b>7-13</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>7-13-67</b> , and that death occurred at <b>1:55 PM</b> , from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>Wm. V. Singleton M.D.</b>  |  | 22b. DATE SIGNED<br><b>7-13-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. V. Singleton</b>   |  | 22d. ADDRESS<br><b>Greater Balto. Medical Center</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>July 17, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>  | 23d. LOCATION (City or town) (County) (State)<br><b>E/Kridge, Rfd., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>R.V. Singleton</b>   |  | 25a. RECEIVED BY REGISTRAR<br><b>JUL 17 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>  |  |   |   |



10000

STATE OF TEXAS

*[Faint, mostly illegible handwritten text, possibly a legal document or a letter, covering the majority of the page.]*

1

JUL 11 1901

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09320

CERTIFICATE OF DEATH

09319

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE,</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>                   |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  |  |  | c. LENGTH OF STAY IN lb<br><b>34 DAYS</b>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  |  |  | d. STREET ADDRESS<br><b>912 ST. PAUL STREET</b>  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>THEODORE K. SNOVELL</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>5</b> Year <b>19 67</b>   |  |   |   |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JANUARY 4, 1900</b>                                  |   |
| 9. AGE (In years last birthday) yrs. <b>67</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PIPE FITTER</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>HAGERSTOWN, MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |   |
| 13. FATHER'S NAME<br><b>WILLIAM SNOVELL</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE NICHOLS</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>YES WW I</b>   |  | 16. SOCIAL SECURITY NO.<br><b>41304 216 07 51-34</b>   |  | 17. INFORMANT<br>Address<br><b>Theo. K. Snovell-316 Roundhill Rd.-21043 CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>                                    |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ANEURYSM, ARTERIOSCLEROTIC ABDOMINAL AORTA, OLD. PULMONARY EMPHYSEMA, OLD</b>   |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                     |  |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'o.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (1) (this hospital) attended the deceased from <b>6/1/67</b> , 19__, to <b>7/5/67</b> , 19__, that (2) (we) last saw the deceased alive on <b>7/5/67</b> , 19__, and that death occurred at <b>1:30PM</b> , from causes and on the date stated above.                          |  |  |  |  |  |   |   |
| 22a. SIGNATURE<br><b>John D. Talbert</b>  |  |  |  | 22b. DATE SIGNED<br><b>7/6/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>               |   |
| 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |  |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>6/7/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |   |
| 24. FUNERAL DIRECTOR<br><b>WITZKE FUNERAL HOME</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 7 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                        |   |
| EDMONDSON AVE. BALTIMORE, MD.   |  |  |  |  |  |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                                    |   |   |   |  |  |  |
|---|--|--|------------------------------------|---|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |                                    |   |   |   |  |  |  |
| 09321   |  |  |                                    |   | 09320   |   |  |  |  |
| 1. PLACE OF DEATH   |  |  |                                    |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                   |   |  |  |  |
| a. COUNTY <b>Baltimore</b>  |  |  |                                    |   | a. STATE <b>Purcellville, Va.</b> b. COUNTY <b>Louden</b>   |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  |  |                                    |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Purcellville</b> |   |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |  |  |                                    |   | d. STREET ADDRESS<br><b>Box 247</b>   |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Sheppard &amp; Enoch Pratt Hospital</b>  |  |  |                                    |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  |                                    |   | 4. DATE OF DEATH  |   |  |  |  |
| First <b>Charles</b> Middle <b>G</b> Last <b>Souder</b>   |  |  |                                    |   | Month <b>July</b> Day <b>4</b> Year <b>1967</b>   |   |  |  |  |
| 5. SEX<br><b>M</b>  |  | 6. COLOR OR RACE<br><b>W</b>                                   |                                    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5-21-1881</b>  |  | 9. AGE (In years last birthday)<br><b>86</b> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Physician</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Co. Health Officer</b> |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Borrowes, Indiana</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>Cloyd Souder</b>  |  |  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Etta Myers</b>  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes Army</b>  |  |  |                                    |   | 16. SOCIAL SECURITY NO.<br><b>224-42-4022</b>   |   |  |  |  |
| 17. INFORMANT<br><b>Wife, Theodate W. Souder, Purcellville, Va.</b>   |  |  |                                    |   | Address   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic brain syndrome due to senility.</b> |  |  |                                    |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><br><b>years</b>                        |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |                                    |   |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                                    |   |   |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> , to <b>July 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1967</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.   |  |  |                                    |   |   |   |  |  |  |
| 22a. SIGNATURE<br><b>R. B. Finn</b>   |  |  |                                    |   |   |   |  | 22b. DATE SIGNED<br><b>July 4, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Rolfe B. Finn, M.D.</b>  |  |  |                                    |   |   |   |  | 22d. ADDRESS<br><b>The Sheppard &amp; Enoch Pratt Hospital</b>                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE THEREOF<br><b>7-7-67</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat. Cemetery</b>                                    |   |  | 23d. LOCATION (City, town or county) (State)<br><b>Arlington VA.</b>                         |  |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>  |  |  |                                    |   |   | 25a. REC'D BY REGISTRAR <b>JUL 6 1967</b> REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |  |  |

There is no doubt that the

As a result, the following are the main findings of the study:

Journal of Great Lakes Research

1000

BAR-5-2

1998

TABLE 5. (continued)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09322

## CERTIFICATE OF DEATH

09321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kingsville</b>  |  | c. LENGTH OF STAY IN TB<br><b>28yrs</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rt#1 Box 15 Belair Road</b>   |  | d. STREET ADDRESS<br><b>Rt#1 Box 15 Belair Road</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Francis</b> Middle <b>Andrew</b> Last <b>Streett</b>  |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>24</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-20-1905</b>                                      |
| 9. AGE (In years last birthday)<br><b>61 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self employed</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Machinery Sale</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Harford Co. Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Francis Andrew Streett</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Webster</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-32-1047</b>   |   |
| 17. INFORMANT<br><b>Mrs Helen M. Streett</b>   |  | Address <b>Kingsville, Md</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>163X</b> IMMEDIATE CAUSE (a) <b>Cancer of Lung</b><br>DUE TO<br>(b) <b>Generalized Metastassis</b><br>DUE TO<br>(c) <b></b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) <del>(his hospital)</del> attended the deceased from <b>October</b> , 19 <b>65</b> to <b>July 24</b> , 19 <b>67</b> that (I) <del>(we)</del> lost saw the deceased alive on <b>July 23</b> , 19 <b>67</b> , and that death occurred at <b>6A.</b> M, from causes on and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>S. Edwin Muller</b> M.D.  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED<br><b>7/24/67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>S. Edwin Muller</b>   |  | 22d. ADDRESS<br><b>1202 St. Paul Street Balto. Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7-26-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stephens Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Radshaw, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>  |  | ADDRESS<br><b>7401 Belair Road</b>  | 25a. REC'D BY REGISTRAR<br><b>JUL 26 1967</b>                             |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Juanita Jones</b>  |   |

00550

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09323

CERTIFICATE OF DEATH

09323

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  | d. STREET ADDRESS<br><b>5228 Cromarty Road</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Baby Boy Strong</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-8-67</b>                                     |
| 9. AGE (In years lost birthday) yrs.<br><b>4</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Richard B. Strong</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Robertson, Dolores, S.,</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mother - Dolores Strong - same</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>776X</b> IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o.m.</b> <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-8</b> , 19 <b>67</b> , to <b>7-8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-8-</b> 19 <b>67</b> , and that death occurred at <b>4:35 P.M.</b> , from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>Jose A. Aguto</b>   |  | 22b. DATE SIGNED<br><b>7-8-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jose A. Aguto, M.D.</b>   |  | 22d. ADDRESS<br><b>7620 York Road, Baltimore, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7-12-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Elkridge, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Charles S. Zeiler</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 13 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Zeiler</b>  |  | 25c. REGISTRAR'S NAME<br><b>Charles Zeiler</b>  |   |

STATE OF TEXAS  
COUNTY OF DALLAS

2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

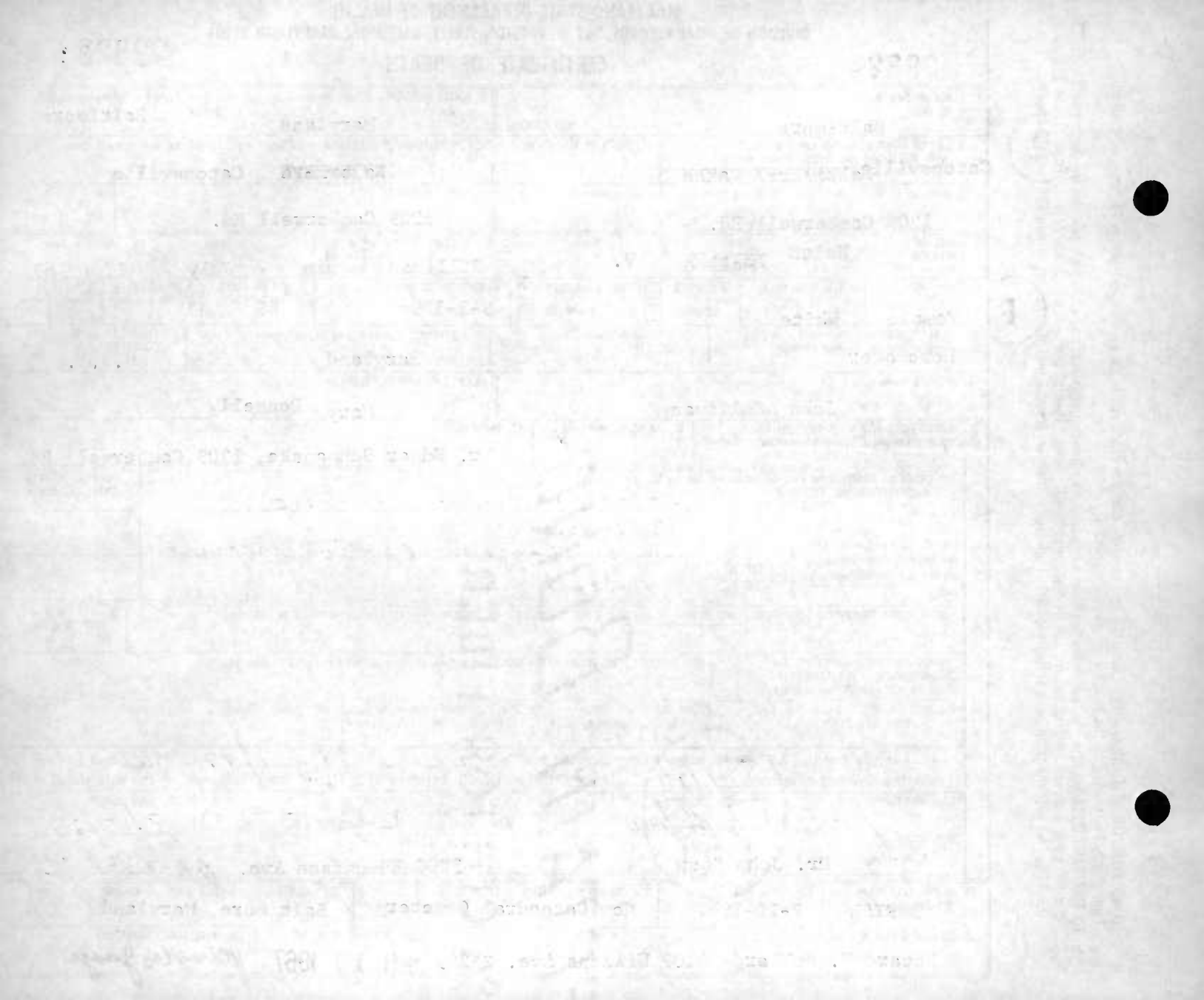
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09324

CERTIFICATE OF DEATH

09323

|   |  |   |                                      |   |  |
|---|--|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>XXXXXX XXXXX</b>  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1209 Camberwell Rd.</b>  |  |   |                                      | d. STREET ADDRESS<br><b>1209 Camberwell Rd.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Helen</b> First <b>XXXXXX</b> Middle <b>V.</b> Last <b>Sullivan</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>17</b> Year <b>1967</b>  |                                      |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-3-1898</b>  | 9. AGE (In years last birthday) yrs.<br><b>68</b>   | 10. IF UNDER 1 YEAR<br>Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |
| 13. FATHER'S NAME<br><b>John Sullivan</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Donnelly</b>  |                                      |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT<br>Address<br><b>Mr. Edgar Schmanske, 1209 Camberwell Rd.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>451X</b> IMMEDIATE CAUSE (a) <b>CAUSE DISSECTING AORTIC</b><br>DUE TO <b>ANEURYSM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO (b) <b>ARTHRITIC RHEUMATOID-UNIONIA</b><br>(c) <b>DISEASE</b> |  |   |                                      |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |                                      |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State) |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/11</b> , 19 <b>67</b> , to <b>7/17</b> , 19 <b>67</b> , that (I) (we) saw the deceased alive on <b>7/17</b> , 19 <b>67</b> , and that death occurred at <b>571 AM</b> , from causes and on the date stated above.  |  |   |                                      |   |  |
| 22a. SIGNATURE<br><b>Dr. John Shaw</b>  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |                                      | 22b. DATE SIGNED<br><b>7/17/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. John Shaw</b>  |  | 22d. ADDRESS<br><b>5800 Edmondson Ave. BALD-28, MD.</b>   |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>7-20-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   |                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard</b>  |  | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>   |                                      | 25a. REC'D BY REGISTRAR<br><b>AUG 19 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09325

CERTIFICATE OF DEATH

09324

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>c. LENGTH OF STAY IN 1b<br><b>#21213</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore #21213</b><br>d. STREET ADDRESS<br><b>3420 Erdman Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Baby Girl "A" Sunderland</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 8 19 67</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>July 8, 1967</b>                                |
| 9. AGE (In years last birthday)<br><b>13</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Mins<br><b>13 10</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Lawrence David Sunderland</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura Jean French</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>5612 Gerland Ave., 21206<br/>Lawrence Sunderland, grandfather</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 19 67</b> , to <b>July 8, 19 67</b> that (I) (we) lost saw the deceased alive on <b>July 8, 19 67</b> , and that death occurred at <b>11:20 PM</b> from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>Jose A. Aguto</b>   |  | 22b. DATE SIGNED<br><b>7-9-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jose A. Aguto, M.D.</b>   |  | 22d. ADDRESS<br><b>7620 York Road, Baltimore, Md 21204</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><b>7/10/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.<br/>3331 Brehms Lane</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUL 11 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |

00352

INSTITUTION OF NORTH

RECEIVED

John Brown

11. January 1861

July 6, 1861

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Religious of...

James David Cunningham

James and French

James and French  
James and French  
James and French

Southwick Engine House, Inc.  
1131 North Main

James and French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09326

CERTIFICATE OF DEATH

09325

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>c. LENGTH OF STAY IN 1b<br><b>#21213</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b> |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>3420 Erdman Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Girl "B" Sunderland</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>1967</b>  |  |   |   |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>July 8, 1967</b>   |   |
| 9. AGE (In years lost birthday) yrs.<br><b>10</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)            |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Maryland</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?   |  |  |  | 13. FATHER'S NAME<br><b>Lawrence David Sunderland</b>  |  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Laura Jean French</b>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |   |   |
| 16. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT <b>5612 Gerland Ave., 21206</b><br><b>Lawrence Sunderland, grandfather,</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO (b) <b>776X</b><br>DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>                      |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'o.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1967</b> , to <b>July 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 8, 1967</b> , and that death occurred at <b>8:30PM</b> , from causes and on the date stated above  |  |  |  |  |  |   |   |
| 22a. SIGNATURE<br><b>Jose A. Aguto</b>   |  |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>7-9-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jose A. Aguto, M.B.</b>   |  |  |  | 22d. ADDRESS<br><b>7620 York Road, Baltimore, Md. 21204</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/10/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                |   |
| 24. FUNERAL DIRECTOR<br><b>Schimmunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                    |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

09327

09326

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randalls town</u>  |                           | c. LENGTH OF STAY IN 1b<br><u>Rockdale</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Balto. County General</u>  |                           | d. STREET ADDRESS<br><u>7928 Donhill Village</u> <u>Circle 13-1</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Joseph</u> First Middle Last <u>Susserman</u>  |                           | 4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1967</u>  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>31 1896</u> 9. AGE (In years last birthday) <u>71</u> <u>MONTHS</u> <u>DAYS</u> <u>HOURS</u> <u>MIN.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY OR CONT. <u>BUILDING</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>AUSTRIA</u>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   |  |
| 13. FATHER'S NAME<br><u>Isaac - Susserman</u>   |                           | 14. MOTHER'S MAIDEN NAME<br><u>Sylvia</u> ?  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Unknown</u>   |                           | 16. SOCIAL SECURITY NO. <u>216-09-6629-A</u>   |  |
| 17. INFORMANT<br><u>Hospital Record</u>   |                           | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Acute pulmonary edema</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <u>Congestive heart failure</u><br>DUE TO (c) <u>Arteriosclerotic heart disease</u> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 hrs</u><br><u>YEARS</u><br><u>YEARS</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>67</u> , to <u>July 4</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>July 4</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes on and on the date stated above.   |                           |  |  |
| 22a. SIGNATURE<br><u>Angela A. Topano</u>   |                           | 22b. DATE SIGNED<br><u>7-4-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ANGELITA TOPANO</u>  |                           | 22d. ADDRESS<br><u>BCDH</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                           | 23b. DATE THEREOF<br><u>7/5/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>NEW HAR SINAI</u>  |                           | 23d. LOCATION (City or Town) (County) (State)<br><u>GARRISON, MARYLAND</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>  |                           | 25a. REC'D BY REGISTRAR<br><u>JUL 7 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jago</u>  |                           |  |  |

CERTIFICATE OF ANALYSIS

1933

Grade

ANALYST'S SIGNATURE

DATE

LABORATORY BUILDING

NO.

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MADE

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 09323   |                                  | Item 2 Film 035N 7/21/67 KK   |  | 09327  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson, Baltimore Co.</b>  |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Armocost Nursing Home</b>  |                                  | d. STREET ADDRESS<br><b>221 Rodgers Forge Road<br/>Register &amp; Sherwood Ave</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY R.</b> Middle <b>BENSON</b> Last <b>SUTTON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>15</b> Year <b>1967</b>   |  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Dec. 29, 1892</b> | 9. AGE (In years lost birthday)<br><b>74 yrs.</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md</b>  |   |
| 13. FATHER'S NAME<br><b>Geo. M. Benson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Virginia Stevens</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>---</b>   |  | 17. INFORMANT<br><b>Mr John R. Sutton, Jr-221 Rodgers Forge Rd.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>444X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Generalized Cerebral Ischemia</b><br>DUE TO<br>(c) <b>Arterio Sclerotic Vascular Disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 hrs</b><br><b>8 hrs</b>  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                     |   |
| 20f. (City or town)   |                                  | 20g. (County)   |  | 20h. (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 13, 1967</b> to <b>July 13, 1967</b> that (I) (we) last saw the deceased alive on <b>July 14, 1967</b> and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.   |                                  |   |  |  |   |
| 22a. SIGNATURE<br><b>Charles F. O'Donnell</b>   |                                  | 22b. DATE SIGNED<br><b>7/16/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Charles F. O'Donnell</b>  |   |
| 22d. ADDRESS<br><b>7501 York Rd. -12</b>  |                                  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/18/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>  |   |
| 23d. LOCATION (City, town, or county)<br><b>Balto. Co.</b>  |                                  |   |  |  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 19 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

CERTIFICATE OF BIRTH

1983

1983

DATE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09329

CERTIFICATE OF DEATH

09328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. <b>Balto.</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE <b>Maryland</b><br>b. COUNTY <b>Balto.</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Randallstown</b>  |  | c. LENGTH OF STAY IN lb<br><b>8 Mo.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3803 Collier Road</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>First <b>Paul</b> Middle <b>W</b> Last <b>Sutton</b>  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>3</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. B. DATE OF BIRTH<br><b>March 6, 1920</b>   |
| 9. AGE (In years last birthday)<br><b>47</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Benefit Examiner</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Cordova, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>John W. Sutton</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bessie Briddell</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes ww 2</b>   |  | 16. SOCIAL SECURITY NO.<br><b>218-09-6325</b>   |   |
| 17. INFORMANT<br><b>Mrs. Doris Sutton</b>  |  | <b>3803 Collier Road</b><br><b>Randallstown, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO <b>4201</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>NO</b> |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour <b>19</b> o.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>10/21</b> , 19 <b>65</b> , to <b>7/3</b> , 19 <b>65</b> , that (I) ( <del>we</del> ) lost the deceased alive on <b>6/28</b> 19 <b>67</b> , and that death occurred at <b>5 A.M.</b> from causes on and on the date stated above  |  |   |   |
| 22a. SIGNATURE<br><b>Ronald Berger</b>   |  | 22b. DATE SIGNED<br><b>7/3/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Balto. Md.</b><br><b>8501 Liberty Rd. 21207</b>   |  | 22d. ADDRESS<br><b>Ronald Berger, M.D.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 23b. DATE THEREOF<br><b>7-6-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Wicomico Co. Md.</b>               |
| 24. FUNERAL DIRECTOR<br><b>Young Byers</b>   |  | 25a. REC'D BY REGISTRAR<br><b>8778 Liberty Rd.</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>JUL 7 1967</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>JUL 7 1967</b>   |   |

2522

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2004/05

2009

modelling

3809 Collier Road

Fig. 1.

Not yet

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1000

 $10^{-2}$  mol.

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1903 Collier House  
West-11th St.

REF ID: A66080



09330

## CERTIFICATE OF DEATH

09329

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  | c. LENGTH OF STAY IN lb<br><b>4 DAYS</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>580 WEST BIDDLE STREET</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>GEORGE EMANUEL TALLIE</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 3, 1967</b>   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/2/97</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>70</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ENTERTAINER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SHOW BUSINESS</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>CULPEPPER, VIRGINIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>GEORGE TALLIE</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>BELLE PARKER</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWI</b>  |  | 16. SOCIAL SECURITY NO.<br><b>294 12 97 99</b>  |  |
| 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO<br>(b) <b>ARTERIOSCLOROTIC HEART DISEASE</b><br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.              |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YEARS</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 29, 1967</b> to <b>JULY 3, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JULY 3, 1967</b> , and that death occurred at <b>7:35 PM</b> , from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><i>Mustafa H. Adatepe</i> M.D.   |  | 22b. DATE SIGNED<br><b>7/4/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MUSTAFA H. ADATEPE, M.D.</b>  |  | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/7/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>ADOLPHUS HAISTEAD FUNERAL HOME</b>  |  | 25a. REC'D BY REGISTRAR<br><b>1206 W. North Ave. Balto, Md.</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                         |

10330

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09331

09330

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cockeysville</u>  |   | c. LENGTH OF STAY IN lb<br><u>747 Mo</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Bonnie Blint Masonic Homes</u>  |   | d. STREET ADDRESS<br><u>506 Kingston Rd.</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Pearl</u> Middle <u>Schultz</u> Last <u>TATE</u>  |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>35</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2/22/84</u>                                    |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>John Schultz</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Minnie Wollman</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u><br>(Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><u>—</u>   |   |
| 17. INFORMANT<br><u>Md Masonic Home, Cockeysville</u>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease</u><br><u>4200</u><br>DUE TO (b) <u>Bilateral Cataract</u><br>DUE TO (c) <u>Cerebral Sclerosis, Chronic Brain Syndrome</u>          |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>July 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 25</u> , 19 <u>67</u> , and that death occurred at <u>7:45 P.M.</u> from causes and on the date stated above. |   |   |   |
| 22a. SIGNATURE<br><u>J. Hamed</u>  |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JAMES HED HAMED</u>   |   | 22d. ADDRESS<br><u>MASONIC HOME</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>July 28, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>London Park</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Wm. Cook-Brooks Towson Inc.</u>   |   | 25a. REC'D BY REGISTRAR<br><u>1050 YORK Rd. Towson, Md. 21204</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | DATE <u>JUL 31 1967</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09332

09331

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Baltimore</u><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Balto.</u>          |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore County</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>Life</u>  |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sparks</u>   |                                  | d. STREET ADDRESS<br><u>Belfast Road</u>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>58 St. Joseph Hospital</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Nellie Taylor</u>  |                                  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>20</u> Year <u>1967</u>   |                                     |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/6 1905</u> |
| 9. AGE (In years last birthday)<br><u>62</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ind.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                     |
| 13. FATHER'S NAME<br><u>Isiah Smith</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Matilda Smith</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |                                     |
| 17. INFORMANT<br><u>Winifred Taylor Sparks, Ind.</u>  |                                  | Address<br><u>  </u>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremic coma</u><br>DUE TO <u>Nephrotic syndrome (K-W syndrome)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>(c) <u>Diabetes Mellitus</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |                                     |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |                                  | 20f. (City or town) (County) (State)<br><u>  </u>   |                                     |
| 21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>7/6</u> , 19 <u>67</u> , to <u>7/20</u> , 19 <u>67</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>7/20</u> , 19 <u>67</u> , and that death occurred at <u>5:10 p.m.</u> from causes and on the date stated above.   |                                  |   |                                     |
| 22a. SIGNATURE<br><u>Jaime Singzon</u>  |                                  | 22b. DATE SIGNED<br><u>  </u>   |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Jaime Singzon, M.D.</u>  |                                  | 22d. ADDRESS<br><u>  </u>   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>7/24/67</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Green Grove</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Md.</u>   |                                     |
| 24. FUNERAL DIRECTOR<br><u>Wm. J. Chaturman Jr. - 1701 Mt. Airy</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>  </u>  |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                  | 25c. DATE<br><u>JUL 24 1967</u>   |                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09333

09332

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>                        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>   |   | c. LENGTH OF STAY IN 1b<br><b>30.4</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>GREATER BALTO. MED CENTER</b>  |   | d. STREET ADDRESS<br><b>4905 Crowson ave.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>AZULA E. TEAWALT</b>  |   | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>7</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-19-79</b>                                     |
| 9. AGE (In years last birthday)<br><b>87</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTO., MD</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |
| 13. FATHER'S NAME<br><b>JAMES MC DONNELL</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>ELIZ. MAC DONALD</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>212-05-6708D</b>  |  |
| 17. INFORMANT<br><b>DAUGHTER</b>  |   | Address<br><b>4905 CROWSON AVE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour a.m. Month, Day, Year<br>p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (a) (this hospital) attended the deceased from <b>JULY 2</b> , 19 <b>67</b> , to <b>JULY 7</b> , 19 <b>67</b> that (b) (we) last saw the deceased alive on <b>JULY 7</b> , 19 <b>67</b> , and that death occurred at <b>12:50 AM</b> , from causes and on the date stated above.                       |   |   |  |
| 22a. SIGNATURE<br><b>Keiffer J. Mitchell</b>  |   | 22b. DATE SIGNED<br><b>7/7/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>KEIFFER J. MITCHELL, M.D.</b>  |   | 22d. ADDRESS<br><b>GREATER BALTO. MED. CENTER</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7-11-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 12 1967</b>   |  |
| ADDRESS<br><b>4905 York Rd. Balto., Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

STATEMENT OF DEATH

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STATEMENT OF DEATH  
I, the undersigned, being a competent witness,  
do hereby certify that on the 10th day of  
April, 1900, at the City of New York,  
in the County of New York, died  
John Doe, of the County of New York,  
in the City of New York, at the age of  
45 years, of the following disease, to-wit:  
Diphtheria.

Witness my hand and seal of office this 10th day of April, 1900.  
J. J. Doe, Mayor of the City of New York.  
Attest:  
J. J. Doe, Clerk of the City of New York.  
J. J. Doe, Recorder of the City of New York.  
J. J. Doe, Comptroller of the City of New York.  
J. J. Doe, Treasurer of the City of New York.  
J. J. Doe, Superintendent of the City of New York.  
J. J. Doe, Commissioner of the City of New York.  
J. J. Doe, Director of the City of New York.  
J. J. Doe, Inspector of the City of New York.  
J. J. Doe, Engineer of the City of New York.  
J. J. Doe, Surveyor of the City of New York.  
J. J. Doe, Assessor of the City of New York.  
J. J. Doe, Collector of the City of New York.  
J. J. Doe, Comptroller of the City of New York.  
J. J. Doe, Treasurer of the City of New York.  
J. J. Doe, Superintendent of the City of New York.  
J. J. Doe, Commissioner of the City of New York.  
J. J. Doe, Director of the City of New York.  
J. J. Doe, Inspector of the City of New York.  
J. J. Doe, Engineer of the City of New York.  
J. J. Doe, Surveyor of the City of New York.  
J. J. Doe, Assessor of the City of New York.  
J. J. Doe, Collector of the City of New York.

FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09334

09334

|  |                                  |   |   |   |  |   |   |
|--|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>12 Years</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b> |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>8534 Kavanagh Road</b>  |                                  |   |   | d. STREET ADDRESS<br><b>8534 Kavanagh Road</b>  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>John N. Trianosky</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>July</b><br>Day<br><b>3</b><br>Year<br><b>19 67</b>   |   |   |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/19/06</b>            | 9. AGE (In years last birthday)<br><b>61</b> yrs.   | IF UNDER 1 YEAR<br>Months<br><b>12</b> | IF UNDER 24 HRS.<br>Days<br><b>3</b><br>Hours<br><b>19</b><br>Min.<br><b>67</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired- Social Security Administration</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Michael Trianosky</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna Danko</b> |   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WWII</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>160-03-2416</b>   |   | 17. INFORMANT (Wife)<br><b>Mrs. Blanche Trianosky, 8534 Kavanagh Rd.</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-V-Disease</b><br>DUE TO (c)  |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)<br><b>None</b>   |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |   |  |   |   |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>   |                                  | EXAMINER'S NAME (Type)<br><b>Melvin B. Davis</b>  |   | M.D.<br><b>M. D.</b>  |  | 22. DATE SIGNED<br><b>7/5/67</b><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 Morningson Rd. Dundalk, Md. 21222</b> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/6/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem. Gardens Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUL 6 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09335

09335

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>BALTO.</b>                      |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>   |  |   |  | c. LENGTH OF STAY IN 1b  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6119 MT. Ridge Rd</b>   |  |   |  | d. STREET ADDRESS<br><b>6119 MT. Ridge Rd</b>  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>MARY A. TRIMPER</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>5</b> Year <b>1967</b>  |  |  |   |
| 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 9, 1889</b>                              |   |
| 9. AGE (In years last birthday) <b>77</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTO. Md</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                          |   |
| 13. FATHER'S NAME<br><b>SPANO</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY BRADY</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212-10-6716 D</b>   |  | 17. INFORMANT<br><b>CATHERINE Kirby</b> Address <b>6119 MT. Ridge Rd</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO <b>ASCVD.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> |  |   |  |  |  |  | ?   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1967</b> to <b>July 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1967</b> , and that death occurred at <b>10:40 A.M.</b> from causes and on the date stated above  |  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><b>I. EARL PASS</b>  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED<br><b>7-5-67</b>                                    |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>I. EARL PASS</b>  |  |   |  | 22d. ADDRESS<br><b>4001 Wilhelmsburg</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>July 8, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Howard Co Md</b> |   |
| 24. FUNERAL DIRECTOR<br><b>E. S. McE Nabb</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>301 Frederick Rd Balto 28 Md.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Jones</b>                  |   |

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Carroll

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

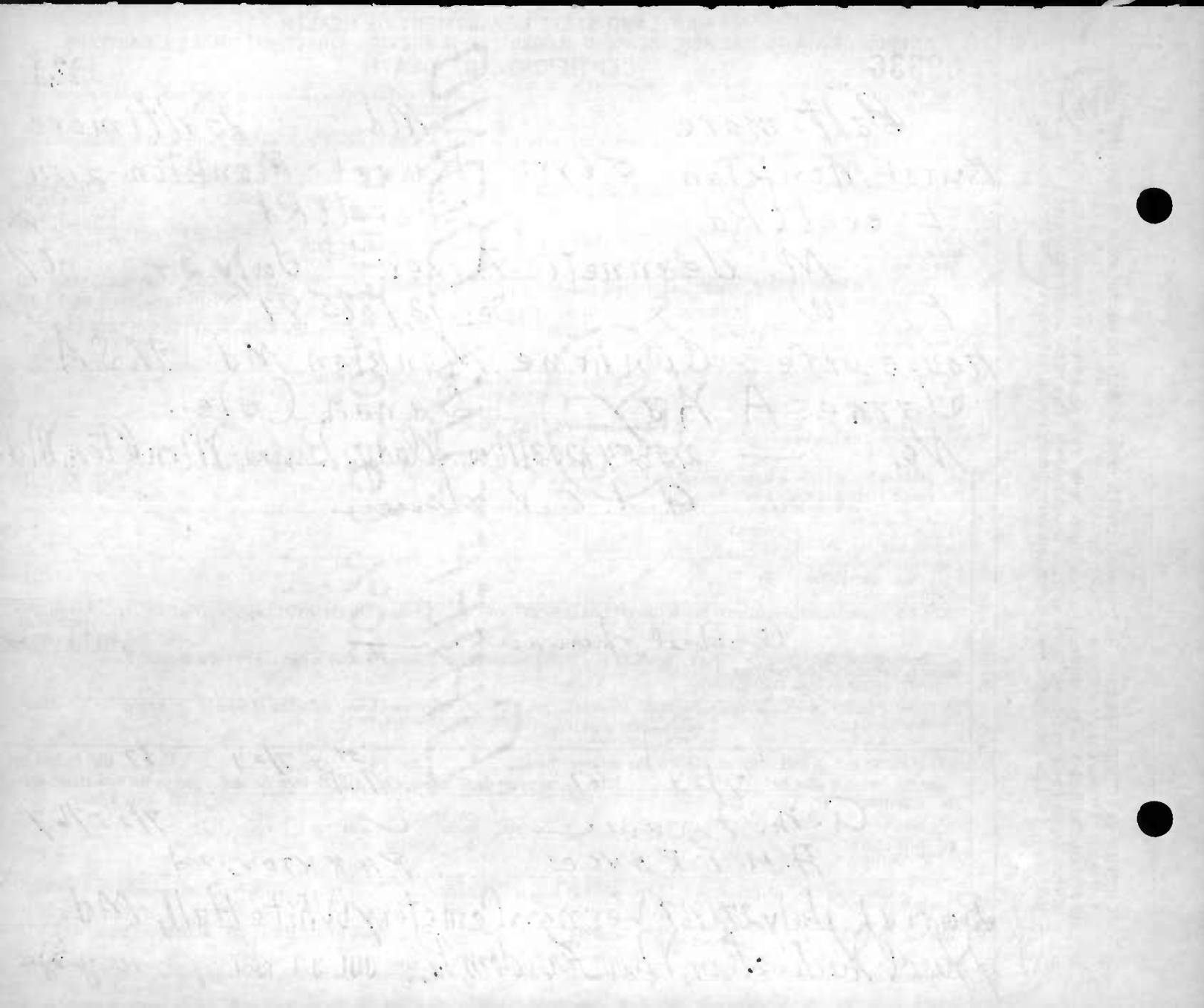
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09336

09333

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton-2111</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Everett Rd.</u>  |  |   |  | d. STREET ADDRESS <u>Everett Rd.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>M. Jeannette Troyer</u>   |  |   |  | 4. DATE OF DEATH <u>July 24, 1967</u>  |  |   |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Dec. 12, 1885</u>                               |  |
| 9. AGE (In years last birthday) <u>81</u> yrs.   |  | 10. IF UNDER 1 YEAR Months Days   |  | 11. IF UNDER 24 HRS. Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |  |   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Monkton, Md.</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |
| 13. FATHER'S NAME <u>James A Kay</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Sarah Cole</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO. <u>215-541203</u>  |  |   |  |
| 17. INFORMANT <u>Mrs. Gladys Burns-Monkton, Md.</u>  |  |   |  | Address <u>Monkton, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C. I. C. V. disease</u><br><u>4221</u><br>DUE TO<br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____ |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage</u>   |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> , 19 <u>67</u> to <u>7/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.                    |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>A. M. France</u> M.D.  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  | 22b. DATE SIGNED <u>7/25/67</u>                                     |  |
| 22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>   |  |   |  | 22d. ADDRESS <u>PARKTON, MD</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF <u>July 27, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u> |  |
| 24. FUNERAL DIRECTOR <u>Isaac Kortenslein, New Freedom, Pa.</u>  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                     |  |
| DATE <u>JUL 31 1967</u>  |  |   |  |  |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>420 Old Trail</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>d. STREET ADDRESS<br><b>420 Old Trail</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Lawrence W. Tuohy</b>  |                                  | 4. DATE OF DEATH<br><b>July 10, 1967</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Nov. 22, 1898</b> |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John J. Tuohy</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Katherine McGaw</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218-22-0488</b>   |  |
| 17. INFORMANT<br><b>Mrs. Gertrude Staley</b>   |                                  | Address<br><b>Same</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4500 Congestive Heart Failure</b><br>DUE TO (b) <b>Atherosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1966</b> , to <b>July 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 10, 1967</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Lawrence C. Post</b>  |                                  | 22b. DATE SIGNED<br><b>7/10/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Lawrence C. Post</b>  |                                  | 22d. ADDRESS<br><b>6805 York Rd. Baltimore, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-13-67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home, Inc.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 13 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                  |   |  |

CERTIFICATE OF MARRIAGE

37

AND ONE

AND ONE

Lawrence A. Henry

Miss

Clara

John A. Henry

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

John A. Henry, husband of Clara

09338

## CERTIFICATE OF DEATH

09337

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lutherville</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>College Manor</b>   |  | d. STREET ADDRESS<br><b>Cecil Apts.</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>ELEANOR Justis TYLER</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 7, 1877</b>                                 |
| 9. AGE (In years last birthday) <b>90</b> yrs.   |  | 10. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>James E. Tyler</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Hamer</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-44-4690</b>   |   |
| 17. INFORMANT<br><b>Mr. J. Edward Tyler</b>  |  | Address<br><b>Maryland</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b><br>DUE TO <b>4221</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO<br>(c) <b>Gastrointestinal bleeding</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Yours</b><br><b>Wks</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 9, 1967</b> to <b>July 2, 1967</b> , that (II) (we) last saw the deceased alive on <b>Jun 28, 1967</b> , and that death occurred at <b>11 A.M.</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>R K Gundry</b>  |  | 22b. DATE SIGNED<br><b>7-3-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Richard Gundry</b>  |  | 22d. ADDRESS<br><b>2 W. University Pkwy.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7-5-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home</b><br><b>Baltimore, Md. 21212</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DATE JUL 5 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

1 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09339

CERTIFICATE OF DEATH

09339

|  |  |  |   |   |  |   |   |
|--|--|--|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  |  | c. LENGTH OF STAY IN lb<br><b>91 DAYS</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK</b> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |  |   | d. STREET ADDRESS<br><b>20 MOBILE COURT</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>LACY</b> Middle <b>JOHN</b> Last <b>TYLER</b>   |  |  |   | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>27</b> Year <b>1967</b>  |  |   |   |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/28/98</b>  |   |
| 9. AGE (In years last birthday) yrs.<br><b>69</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PIPEFITTER</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>CHANCE, MARYLAND</b>                    |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |   | 13. FATHER'S NAME<br><b>JOHN T. TYLER</b>   |  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>ELLA JONES</b>  |  |  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWI</b>                                   |  |   |   |
| 16. SOCIAL SECURITY NO.<br><b>219 14 48 59</b>   |  |  |   | 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL, ASPIRATION, UNDETERMINED</b><br>DUE TO <b>ORGANISM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>—</b><br>DUE TO <b>RT. MIDDLE CEREBRAL ARTERY THROMBOSIS</b><br>(c) <b>90 DAYS</b> |  |  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>HYPERTENSIVE VASCULAR DISEASE</b>   |  |  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work at work     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>APRIL 27, 1967</b> , to <b>JULY 27, 1967</b> , that <b>he</b> (we) last saw the deceased alive on <b>JULY 27, 1967</b> , and that death occurred at <b>7:10 PM</b> , from causes and on the date stated above.  |  |  |   |   |  |   |   |
| 22a. SIGNATURE<br><i>Neilon Neilson</i>  |  |  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>7/28/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILON NEILSON, M.D.</b>  |  |  |   | 22d. ADDRESS<br><b>VAH, FORT HOWARD, MARYLAND</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>7/31.67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |   |
| 24. FUNERAL DIRECTOR<br><b>ULLAH FUNERAL HOME</b>  |  |  |   | ADDRESS<br><b>2112 DUNDALK AVENUE DUNDALK, MD.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 1 1967</b>   |   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judges</i>   |  |   |   |

00339

CERTIFICATE OF DEATH

STATE OF NEW YORK  
COUNTY OF [illegible]  
I, [illegible],  
[illegible]  
[illegible]

that [illegible]  
[illegible]  
[illegible]  
[illegible]  
[illegible]

was [illegible]  
[illegible]  
[illegible]  
[illegible]  
[illegible]

at [illegible]  
[illegible]  
[illegible]

on [illegible]  
[illegible]  
[illegible]

at [illegible]  
[illegible]  
[illegible]

in [illegible]  
[illegible]  
[illegible]

at [illegible]  
[illegible]  
[illegible]

in [illegible]  
[illegible]  
[illegible]

at [illegible]  
[illegible]  
[illegible]

in [illegible]  
[illegible]  
[illegible]

CERTIFICATE OF DEATH

09340

09339

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>             |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>  |  |  |  | c. LENGTH OF STAY IN 1b  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. JOSEPH CONV. HOME</b>  |  |  |  | d. STREET ADDRESS <b>2038 E. PRATT ST</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>TEOFILA</b> <b>USTASZEWSKA</b>  |  |  |  | 4. DATE OF DEATH <b>JULY 2 1967</b>  |  |   |  |
| 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>5-30-1891</b>                                   |  |
| 9. AGE (In years last birthday) <b>76</b> yrs.   |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>   |  |
| 13. FATHER'S NAME <b>? KOSMACZEWSKI</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>SOPHIE WIEDECK 3547 JUNEWAY</b> Address            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b><br><b>2931</b> DUE TO <b>ANEMIA</b><br>Conditions, if any, which gave rise to immediate cause (b) DUE TO<br>(a), stating the underlying cause last. (c) |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2 July, 1967</b> to <b>2 July, 1967</b> , that (I) (we) last saw the deceased alive on <b>2 July, 1967</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| 22a. SIGNATURE <b>Ralph E. Updike MD.</b> M.D.   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <b>3 July 67</b>                                   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Ralph E. Updike MD.</b>  |  |  |  | 22d. ADDRESS <b>31 Dogwood Dr. - ELlicott city, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>7-5-1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM.</b>   |  | 23d. LOCATION (City, town or county) (State) <b>BALTO. MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Weber</b> ADDRESS <b>JOHN M. WEBER &amp; SONS INC 4015 CHESTER ST.</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| DATE <b>JUL 3 1967</b>   |  |  |  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





CERTIFICATE OF DEATH

1907

For the County of

State of Illinois

John Doe

Age 50

Married

Occupation

Residence

Dec 10

John Doe

Dec 10

John Doe



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09341

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b> <i>23.1</i>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>9300 Corney Road</b>  |                                  | d. STREET ADDRESS<br><b>9300 Corney Road</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>WILLIAM WALLACE</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>7</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>8-21-25</b>                                     |
| 9. AGE (In years last birthday) yrs. <b>41</b>   |                                  | IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Garretaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cemetery</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>George F. Wallace</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Dollie *****</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b> <b>WW2</b>   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Family Records</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4200</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____   |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State)   |                                  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |  |
| ACTUAL SIGNATURE<br><i>Charles S. Springate</i><br>EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |  |
| 22. DATE SIGNED<br><b>July 7, 1967</b>   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7/10/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>C.F. EVANS &amp; SON 8802 Harford rd.</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>James J. Jones</i>  |                                  |  |  |

MEDICAL CERTIFICATION

32543

WILLIAM, GEORGE, 1880-1900

WILLIAM, GEORGE, 1880-1900

1880-1900

1880-1900

Parkville

Parkville

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

Family Records

Family Records

1880-1900

1880-1900



1880-1900

1880-1900

1880-1900

1880-1900

1880-1900

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09343

09343

|  |                                  |  |                                   |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>            |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>11 mos.</b>  |                                   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Churchill</b>   |                                  | 17-2   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>   |                                  | d. STREET ADDRESS<br><b>R.F.D. #25</b>   |                                   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> ?   |                                  |  |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cynthia</b> Middle <b>Louise</b> Last <b>WALLS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>20</b> Year <b>19 67</b>   |                                   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-2-66</b> |
| 9. AGE (In years last birthday)<br><b>1</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>20</b> Hours <b>19</b> Min. <b>67</b>   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Queen Anne County, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                   |
| 13. FATHER'S NAME<br><b>Thomas Walls</b>   |                                  | 14. MOTHER'S MAIDEN NAME   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |                                   |
| 17. INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>   |                                  | Address  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INFECTED MENINGOMYELOCOELE</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>951X</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>ARNOLD CHIARI MALFORMATION, HYDROCOEPHALUS, CLIFT LIP</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (X) (this hospital) attended the deceased from <b>8/12/66</b> , 19__ to <b>7/20/67</b> , 19__, that (X) (we) last saw the deceased alive on <b>7-20-67</b> , 19__, and that death occurred at <b>1:10 P.M.</b> from causes and on the date stated above.  |                                  |  |                                   |
| 22a. SIGNATURE<br><i>Placido V. J. Macaraeg, Jr.</i>   |                                  | 22b. DATE SIGNED<br><b>7-20-67</b>   |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Placido V. J. Macaraeg, Jr.</b>   |                                  | 22d. ADDRESS<br><b>Rosewood State Hosp., Owings Mills, Md.</b>   |                                   |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>7-24-67</b>   |                                  | 23b. DATE THEREOF  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>U.S. Md. Med. School</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>  |                                   |
| 24. FUNERAL DIRECTOR<br><i>Revel Funeral Home</i>  |                                  | 25a. REC'D BY REGISTRAR<br><b>AUG 1 1967</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Richard Judge</i>   |                                  |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CERTIFICATE OF DEATH

1942

|                        |  |                        |  |                        |  |                             |  |                         |  |                       |  |
|------------------------|--|------------------------|--|------------------------|--|-----------------------------|--|-------------------------|--|-----------------------|--|
| Name of Deceased       |  | Date of Birth          |  | Sex                    |  | Race                        |  | Marital Status          |  | Occupation            |  |
| John Doe               |  | 1/1/1900               |  | Male                   |  | White                       |  | Married                 |  | Farmer                |  |
| Place of Birth         |  | Date of Death          |  | Time of Death          |  | Cause of Death              |  | Place of Death          |  | Manner of Death       |  |
| New York, N.Y.         |  | 12/31/1941             |  | 10:00 AM               |  | Heart Disease               |  | Home                    |  | Natural               |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Informant |  | Signature of Burial Officer |  | Signature of Undertaker |  | Signature of Cemetery |  |
| [Signature]            |  | [Signature]            |  | [Signature]            |  | [Signature]                 |  | [Signature]             |  | [Signature]           |  |

John Doe, born 1/1/1900, died 12/31/1941, cause of death Heart Disease, place of death Home, manner of death Natural.



1942

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09343

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>BALTIMORE</b>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jarrettsville Pike, Sunnybrook</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Balto, Jarrettsville Pike, Sunnybrook</b>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Jarrettsville Road</b>  |                                  | d. STREET ADDRESS<br><b>3701 Milford Avenue</b>   |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARY SHIRLEY WATT</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>7</b> Year <b>1967</b>   |                                      |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-18-1932</b> |
| 9. AGE (In years last birthday)<br><b>35 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>30.4</b>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      |
| 13. FATHER'S NAME<br><b>Raymond B. Dorn</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Stengel</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>William Watt-Oakland Rd. Sykesville, Maryland</b>   |                                      |
| 17. INFORMANT<br><b>Address</b>  |                                  |   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b><br><b>587.0</b><br>DUE TO <b>Acute pancreatitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Fatty metamorphosis of liver</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                      |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b><br>EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>   |                                  | 22. DATE SIGNED<br><b>July 7, 1967</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>7-11-1967</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto National Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |                                      |
| 24. FUNERAL DIRECTOR<br><b>4800 Liberty Hgts. Avenue</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1967</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Springate</b>  |                                  |   |                                      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09345

09344

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RFD Edgewater, Maryland</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>   |  | d. STREET ADDRESS<br><b>None</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Nellie Mae Webb</b>  |  | 4. DATE OF DEATH <b>July.29th</b> 19 <b>67</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-10-94</b>                                     |
| 9. AGE (In years <b>72</b> yrs.)   |  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nurse (Pract.)</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Missouri</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 13. FATHER'S NAME<br><b>John Hartzell</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Maggie Hooper</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO.<br><b>219-54-3465</b>  |  | 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)                   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Up railing 7/18/67</b>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. 19<br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 11, 1967</b> , to <b>7/29, 1967</b> , that (I) (we) last saw the deceased alive on <b>7-29 1967</b> , and that death occurred at <b>5:00 P.M.</b> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>Robert Fisher</b>   |  | 22b. DATE SIGNED<br><b>7/29/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert Fisher</b>   |  | 22d. ADDRESS<br><b>Spring Grove State Hospital<br/>Baltimore, Maryland 21228</b>  |   |
| 23a. BURIAL, CREMATION, or other disposition<br><b>Cremation</b>   | 23b. DATE THEREOF<br><b>7.31.67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cremation Lee's</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D C.</b> |
| 24. FUNERAL DIRECTOR<br><b>LEE FUNERAL HOME 300 F ST. N.E.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 1 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>                      |

1934

STATE OF TEXAS

Ballroom

Marshall

John A. Smith

Colonial

W. J. Brown

Spring Grove Hotel

John

July 1934

Mar

Apr

White

10-21

1934

White (1934)

White

White (1934)

White (1934)

1934-1935

1934-1935

1934-1935

1934-1935

Robert Fisher

Gravitation

Operation

1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

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09346

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09345

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | MARYLAND<br>c. LENGTH OF STAY in lb<br><b>7 hrs. 6 min.</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Balto.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21204</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                  |   |   | d. STREET ADDRESS<br><b>353 Eudowood Lane</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Girl</b>  |                                  | First<br><b>Weems</b>   |   | 4. DATE OF DEATH<br>Month<br><b>July</b><br>Day<br><b>21</b><br>Year<br><b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 21, 1967</b>                |  | 9. AGE (In years last birthday) yrs.<br><b>7</b> Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>Weems, James Stanley</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Whye, Beatrice Marie</b> |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT<br><b>ps. Weems 631 Chellow ave. Balto. Md</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>7610 Intra-uterine pneumonia</b><br>DUE TO<br>(b) <b>Premature rupture of membranes</b><br>DUE TO<br>(c)   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town) (County) (State)  |                                  |   |   |  |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 21, 19 67</b> , to <b>July 21, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 21, 19 67</b> , and that death occurred at <b>9:50 PM</b> , from causes and on the date stated above. |                                  |   |   |  |   |
| 22a. SIGNATURE<br><b>Lawrence D. Misanik</b>  |                                  |   |   | 22b. DATE SIGNED<br><b>July 21, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence Misanik, M.D.</b>   |                                  |   |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/27/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>  |                                  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br><b>Wm. D. Chatman</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 26 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09347

CERTIFICATE OF DEATH

09346

|  |                               |   |  |   |  |
|--|-------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>   |                               | MARYLAND<br>c. LENGTH OF STAY IN 1b <b>28yrl3dys</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>  |                               |   |  | d. STREET ADDRESS <b>2807 Clifton Street</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Margaret</b>   |                               | First Middle Last <b>Weller</b>   |  | 4. DATE OF DEATH <b>July 19, 1967</b>   |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | B. DATE OF BIRTH <b>April 16, 1900</b> |   | 9. AGE (In years last birthday) <b>67</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Maryland</b>   |  |
| 13. FATHER'S NAME <b>Bartholomew Andrew</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Mary Neubart</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Breasts, type undetermined, 1 yr.</b><br><b>with generalized metastases</b><br>DUE TO (b) <b>(family refused permission for biopsy.)</b><br>DUE TO (c) <b>ONSET AND DEATH</b> |                               |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |                               | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 6, 1967</b> to <b>July 19, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 19, 1967</b> , and that death occurred at <b>1:38</b> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <b>Anthony J. Young, M.D.</b>   |                               | 22b. DATE SIGNED <b>7-19-67</b>   |  | 22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 23b. DATE THEREOF <b>7/21/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>   |  |
| 24. FUNERAL DIRECTOR <b>ES. 77th St</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>BALTO MD.</b>  |  | 25a. REC'D BY REGISTRAR <b>JUL 24 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |                               | 25c. ADDRESS <b>301 Trubank Rd Baltimore Md</b>   |  |   |  |

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California

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |   |   |  |  |   |
|---|---|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |   |  |  |   |
| CERTIFICATE OF DEATH  |   |   |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Towson</b>   |   | c. LENGTH OF STAY IN lb<br><b>13 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>   |   |   | d. STREET ADDRESS<br><b>1741 Freedomway North</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>FRANCIS HENRY WELSH</b>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>July 20, 1967</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 1, 1928</b>   | 9. AGE (In years lost birthday) yrs.<br><b>39</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Packing Shipping</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bendix Radio</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Carroll County, Md.</b>                    |   |
| 13. FATHER'S NAME<br><b>Albert Welsh</b>  |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>215-20-8171</b>   |  | 17. INFORMANT<br><b>Grimes, Mary E.</b><br>Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County)   | (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1967</b> , to <b>July 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 20, 1967</b> , and that death occurred <b>11:00 A.M.</b> from causes and on the date stated above.                                 |   |   |  |  |   |
| 22a. SIGNATURE<br><b>John E. Adams</b>  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>         |  | 22b. DATE SIGNED<br><b>7/20/67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>  |   |   | 22d. ADDRESS<br><b>Greater Baltimore Medical Center</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/22/1967</b>   | 23c. NAME OF CEMETERY<br><b>Winfield Church Of God</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Carroll Co., Md.</b>   |  |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>C. M. Waltz Box 241 Sykesville, Md.</b>   |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUL 24 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

DECLARATION OF DEATH

John S. Adams

1961 JUL 2 1 00 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                              |   |                                      |
|--|------------------------------|---|--------------------------------------|
| 09348  |                              | 09348   |                                      |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN lb<br><b>30.4</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Chesapeake Manor Nursing Home</b>                    |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson Baltimore</b><br>d. STREET ADDRESS<br><b>4144 Roland Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Louise C. Wilhelm</b>   |                              | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>9</b> Year <b>1967</b>  |                                      |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>7-18-1885</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>81</b>  |                              | 10. IF UNDER 1 YEAR<br>Months <b>20</b> Days <b>10</b> Hours <b>15</b> Min.   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Rohleder</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>220-30-5828</b>   |                                      |
| 17. INFORMANT<br><b>Mr. Charles R. Goldsborough, Jr.</b>   |                              | Address<br><b>Balto., Md.</b>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1538</b><br>IMMEDIATE CAUSE (a) <b>Cancer of Colon</b><br>DUE TO (b) <b>Interval between onset and death</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c) |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 1965</b> to <b>July 1967</b> , that (I) (we) last saw the deceased alive on <b>July 1967</b> , and that death occurred at <b>2:00 PM</b> from causes and on the date stated above.   |                              |   |                                      |
| 22a. SIGNATURE<br><b>William G. Helfrich</b>   |                              | 22b. DATE SIGNED  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. William G. Helfrich</b>   |                              | 22d. ADDRESS<br><b>5006 Roland Avenue</b>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                              | 23b. DATE THEREOF<br><b>7-12-67</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |                                      |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>JUL 12 1967</b>   |                                      |
| ADDRESS<br><b>4905 York Road Balto., Md.</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                      |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09330

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09349

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Baltimore MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Balto.                              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Baltimore  |  |   |  | c. LENGTH OF STAY IN 1b<br>1 day   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>St Joseph Hospital   |  |   |  | e. STREET ADDRESS<br>Freeland Maryland   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Nellie R. Williams   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br>July 2 1967  |  |   |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>white   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>8/21/20                                     |  |
| 9. AGE (In years last birthday)<br>46 yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own home                   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br>York Co. Penna.   |  | 12. CITIZEN OF WHAT COUNTRY<br>U. S. A.   |  | 13. FATHER'S NAME<br>Frank Doll  |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br>Emma Stokes  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  |   |  |
| 16. SOCIAL SECURITY NO.<br>220-545070  |  |   |  | 17. INFORMANT<br>Albert Doll, Freeland, Md.  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Pulmonary edema<br>DUE TO Congestive Heart failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Probable myocardial infarction<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                            |  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br>[Signature]  |  |   |  | 22b. DATE SIGNED<br>7/2/67   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>M.D.   |  |   |  | 22d. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify)   |  | 23b. DATE THEREOF<br>July 5, 1967   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wiseburg Cemetery  |  | 23d. LOCATION (City, town or county) (State)<br>White Hall, Md. |  |
| 24. FUNERAL DIRECTOR<br>Jacob Hartenstein, New Freedom, Pa.  |  |   |  | 25a. REC'D BY REGISTRAR<br>JUL 7 1967  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |   |  |  |  |   |  |

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MDARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09351

CERTIFICATE OF DEATH

09350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                              |   |                                    |  |                                |   |                               |
|--|------------------------------|---|------------------------------------|--|--------------------------------|---|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                              |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u><br><u>141 Hickory Ave</u> |                                |   |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |                              | c. LENGTH OF STAY IN TB<br><u>6 days</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bel Air Md.</u>   |                                |   |                               |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>333 Harlem Lane Shaugrisa Nsg. Home</u>   |                              |   |                                    | d. STREET ADDRESS<br><u>141 Hickory Ave. Shaugrisa Nsg. Home</u>   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |
| 3. NAME OF DECEASED (Type or print)<br>First (EARL) Middle Last<br><u>Norris</u> <u>Earl</u> <u>Wimmer</u>   |                              |   |                                    | 4. DATE OF DEATH<br>Month Day Year<br><u>July</u> <u>13</u> <u>1967</u>  |                                |   |                               |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-13-08</u> | 9. AGE (In years last birthday)<br><u>59</u> yrs.  | IF UNDER 1 YEAR<br>Months Days |   | IF UNDER 24 HRS<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Aircraft Mechanic</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Aircraft</u>  |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Va.</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                               |
| 13. FATHER'S NAME<br><u>William Ezra Wimmer</u>  |                              |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Lois Elizabeth Walton</u>   |                                |   |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Unknown</u> <u>NO</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>215-14-8787</u>   |                                    | 17. INFORMANT (with Address)<br><u>Mrs. ANNA E. Wimmer 141 Hickory Ave. Bel Air Maryland 21014</u>   |                                |   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>331x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Cerebral Vascular Accidents</u><br>DUE TO (c) <u></u> |                              |   |                                    |  |                                | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 1/2 yrs</u>  |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes mellitus</u>  |                              |   |                                    |  |                                | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |  |                                |   |                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                | 20f. (City or town) (County) (State)  |                               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6 July</u> , 19 <u>67</u> , to <u>13 July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 July</u> , 19 <u>67</u> , and that death occurred at <u>6 A.M.</u> from causes on and on the date stated above.   |                              |   |                                    |  |                                |   |                               |
| 22a. SIGNATURE<br><u>John K. W. Leagly</u>   |                              |   |                                    | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                      |                                | 22b. DATE SIGNED<br><u>13 July 1967</u>   |                               |
| 22c. PHYSICIAN'S NAME (Type)   |                              |   |                                    | 22d. ADDRESS   |                                |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>July 15, 1967</u>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Stephens Cath. Ch. Cem.</u>   |                                | 23d. LOCATION (City or Town) (County) (State)<br><u>Bradshaw Balto. Co. Maryland</u>              |                               |
| 24. FUNERAL DIRECTOR<br><u>Joseph William Foster</u>   |                              |   |                                    | ADDRESS<br><u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>   |                                | 25a. REC'D BY REGISTRAR<br><u>JUL 17 1967</u>   |                               |
|  |                              |   |                                    | 25b. REGISTRAR'S SIGNATURE<br><u>John K. W. Leagly</u>   |                                |   |                               |

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CERTIFICATE OF DEATH

|                                 |  |                                 |  |                                 |  |                                   |  |
|---------------------------------|--|---------------------------------|--|---------------------------------|--|-----------------------------------|--|
| 1. Name of deceased             |  | 2. Sex                          |  | 3. Age                          |  | 4. Date of death                  |  |
| 5. Place of death               |  | 6. Cause of death               |  | 7. Manner of death              |  | 8. Signature of physician         |  |
| 9. Signature of registrar       |  | 10. Signature of informant      |  | 11. Signature of witness        |  | 12. Signature of coroner          |  |
| 13. Signature of undertaker     |  | 14. Signature of funeral home   |  | 15. Signature of cemetery       |  | 16. Signature of church           |  |
| 17. Signature of family         |  | 18. Signature of friends        |  | 19. Signature of neighbors      |  | 20. Signature of community        |  |
| 21. Signature of school         |  | 22. Signature of employer       |  | 23. Signature of business       |  | 24. Signature of government       |  |
| 25. Signature of military       |  | 26. Signature of naval          |  | 27. Signature of air force      |  | 28. Signature of space            |  |
| 29. Signature of intelligence   |  | 30. Signature of defense        |  | 31. Signature of justice        |  | 32. Signature of education        |  |
| 33. Signature of health         |  | 34. Signature of labor          |  | 35. Signature of agriculture    |  | 36. Signature of industry         |  |
| 37. Signature of commerce       |  | 38. Signature of transportation |  | 39. Signature of communication  |  | 40. Signature of energy           |  |
| 41. Signature of environment    |  | 42. Signature of science        |  | 43. Signature of technology     |  | 44. Signature of innovation       |  |
| 45. Signature of culture        |  | 46. Signature of arts           |  | 47. Signature of sports         |  | 48. Signature of recreation       |  |
| 49. Signature of entertainment  |  | 50. Signature of media          |  | 51. Signature of advertising    |  | 52. Signature of public relations |  |
| 53. Signature of marketing      |  | 54. Signature of sales          |  | 55. Signature of distribution   |  | 56. Signature of retail           |  |
| 57. Signature of wholesale      |  | 58. Signature of export         |  | 59. Signature of import         |  | 60. Signature of trade            |  |
| 61. Signature of finance        |  | 62. Signature of banking        |  | 63. Signature of insurance      |  | 64. Signature of investment       |  |
| 65. Signature of real estate    |  | 66. Signature of construction   |  | 67. Signature of engineering    |  | 68. Signature of architecture     |  |
| 69. Signature of design         |  | 70. Signature of manufacturing  |  | 71. Signature of processing     |  | 72. Signature of assembly         |  |
| 73. Signature of packaging      |  | 74. Signature of distribution   |  | 75. Signature of retail         |  | 76. Signature of service          |  |
| 77. Signature of support        |  | 78. Signature of maintenance    |  | 79. Signature of repair         |  | 80. Signature of replacement      |  |
| 81. Signature of disposal       |  | 82. Signature of recycling      |  | 83. Signature of reuse          |  | 84. Signature of repurpose        |  |
| 85. Signature of renovation     |  | 86. Signature of restoration    |  | 87. Signature of reconstruction |  | 88. Signature of reconstruction   |  |
| 89. Signature of reconstruction |  | 90. Signature of reconstruction |  | 91. Signature of reconstruction |  | 92. Signature of reconstruction   |  |
| 93. Signature of reconstruction |  | 94. Signature of reconstruction |  | 95. Signature of reconstruction |  | 96. Signature of reconstruction   |  |
| 97. Signature of reconstruction |  | 98. Signature of reconstruction |  | 99. Signature of reconstruction |  | 100. Signature of reconstruction  |  |

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Manner of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant  
11. Signature of witness  
12. Signature of coroner  
13. Signature of undertaker  
14. Signature of funeral home  
15. Signature of cemetery  
16. Signature of church  
17. Signature of family  
18. Signature of friends  
19. Signature of neighbors  
20. Signature of community  
21. Signature of school  
22. Signature of employer  
23. Signature of business  
24. Signature of government  
25. Signature of military  
26. Signature of naval  
27. Signature of air force  
28. Signature of space  
29. Signature of intelligence  
30. Signature of defense  
31. Signature of justice  
32. Signature of education  
33. Signature of health  
34. Signature of labor  
35. Signature of agriculture  
36. Signature of industry  
37. Signature of commerce  
38. Signature of transportation  
39. Signature of communication  
40. Signature of energy  
41. Signature of environment  
42. Signature of science  
43. Signature of technology  
44. Signature of innovation  
45. Signature of culture  
46. Signature of arts  
47. Signature of sports  
48. Signature of recreation  
49. Signature of entertainment  
50. Signature of media  
51. Signature of advertising  
52. Signature of public relations  
53. Signature of marketing  
54. Signature of sales  
55. Signature of distribution  
56. Signature of retail  
57. Signature of wholesale  
58. Signature of export  
59. Signature of import  
60. Signature of trade  
61. Signature of finance  
62. Signature of banking  
63. Signature of insurance  
64. Signature of investment  
65. Signature of real estate  
66. Signature of construction  
67. Signature of engineering  
68. Signature of architecture  
69. Signature of design  
70. Signature of manufacturing  
71. Signature of processing  
72. Signature of assembly  
73. Signature of packaging  
74. Signature of distribution  
75. Signature of retail  
76. Signature of service  
77. Signature of support  
78. Signature of maintenance  
79. Signature of repair  
80. Signature of replacement  
81. Signature of disposal  
82. Signature of recycling  
83. Signature of reuse  
84. Signature of repurpose  
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

09352

09351

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgemere</b>  |                                     | c. LENGTH OF STAY IN lb<br><b>10 Years</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6400 Old North Point Road</b>   |                                     | d. STREET ADDRESS<br><b>6400 Old North Point Road</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Edward Thomas Wojcik</b>   |                                     | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH<br><b>9/28/09</b>                                     |
| 9. AGE (In years last birthday) yrs. <b>57</b>   |                                     | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>19</b> Hours <b>67</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Leary Co. Inc.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Edward Wojcik</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Susan Strugale</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>216-10-7781</b>   |  |
| 17. INFORMANT<br><b>Mrs. Theresa Bykowski, 6400 Old North Pt. Rd.</b>  |                                     | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V-DISEASE</b><br>DUE TO (b) <b>Obesity</b><br>DUE TO (c) <b>Obesity</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                     |   |  |
| ACTUAL SIGNATURE <b>Melvin B. Davis</b>  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7/11/67 22. DATE SIGNED   |  |
| EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>  |                                     | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningson Rd.   |  |
| M. D.  |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, Md. 21222</b>   |  |
| Address (Street, city, town, or county)  |                                     |   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/14/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |                                     | 25a. REC'D BY REGISTRAR<br><b>JUL 13 1967</b>   |  |
| ADDRESS  |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Jones</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09352

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                       |  |   |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>BALTIMORE</b>                                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sparrows Point</b>   |                                       | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Bethlehem Steel Company</b>  |                                       | d. STREET ADDRESS<br><b>1125 Steelton Avenue</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>GEORGE F. WOJCIK</b>   |                                       | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>27</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          | 8. DATE OF BIRTH<br><b>July 20, 1914</b>  |
| 9. AGE (In years last birthday) yrs. <b>53</b>  |                                       | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>3</b> Hours <b>30</b> Min. <b>4</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steel Maker</b>   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |                                       | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>Paul Wojcik</b>   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Sophia Giza</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) <b>Yes</b> <b>WW II</b>   |                                       | 16. SOCIAL SECURITY NO.<br><b>216-01-7598</b>  |   |
| 17. INFORMANT<br><b>Paul Wojcik</b>   |                                       | Address<br><b>1125 Steelton Avenue</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Crushing injuries of trunk</b><br>DUE TO (b) <b>830.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>830.0</b><br>DUE TO (c)  |                                       |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                       |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Walked in front of Fork-lift truck and run over</b>                               |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>7:00</b> p.m. <b>7-27</b> 19 <b>67</b>  |                                       | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)<br><b>foundry</b>          |
| 20f. (City or town) <b>Sparrows Point</b> (County) <b>Balt.</b> (State) <b>Md.</b>  |                                       |  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                       |  |   |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>   |                                       | 22. DATE SIGNED<br><b>July 28, 1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>   |                                       | Address (Street, city, town, or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7-31-1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Lilly &amp; Zeiler Inc.</b>  |                                       | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 31 1967</b>   |   |
| ADDRESS<br><b>1901-07 Eastern Ave.</b>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

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Paul Wojcik

1127 Seashore Avenue  
Paul Wojcik  
Baltimore, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09354

09353

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>e. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE (RURAL)</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WHITE HALL</u> 03-1  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>HOUSE IN PINES 16 FUSTING AVE</u>   |   | d. STREET ADDRESS<br><u>RT 1 Box 260</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>WILLIAM ROY WOODS</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>JULY 18 1967</u>   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MAR. 17, 1894</u>                               |
| 9. AGE (In years last birthday)<br><u>73</u> yrs.  |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LABORER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MISCELL.</u>  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>NEBRASKA</u> |
| 13. FATHER'S NAME<br><u>WARREN WOODS</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>LUCY</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>564-16-7202A</u>  |  |
| 17. INFORMANT<br><u>MRS BEATRICE WOODS</u>   |   | Address<br><u>WHITE HALL, MD.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Ca of Brain</u><br>1621 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Primary Ca of Lung</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u><br><u>18 mos</u>      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) ( <u>Mrs</u> hospital) attended the deceased from <u>5-20-</u> , 1967, to <u>7-18-</u> , 1967, that (I) ( <u>we</u> ) last saw the deceased alive on <u>7-17-1967</u> , and that death occurred at <u>3P.M.</u> , from the causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>Wilmer K. Gallagher</u> M.D.  |   | 22b. DATE SIGNED<br><u>7/18/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Wilmer K. Gallagher</u>   |   | 22d. ADDRESS<br><u>6209 Frederick Ave. Balt. 21225 Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>CREMATION</u>  |   | 23b. DATE THEREOF<br><u>7/19/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>GREENMOUNT CEM.</u>   |   | 23d. LOCATION (City, town or county) (State)<br><u>BALTIMORE, MD.</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>JOHN F. DENNY, INC</u>  |   | ADDRESS<br><u>715 LIGHT ST.</u>   |  |
| 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 20 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

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## CERTIFICATE OF DEATH

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| 1. PLACE OF BIRTH<br>a. COUNTY <u>Balto.</u> <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> <u>Baltimore</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Balto.</u> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Rose</u> First <u>NMI</u> Middle <u>Woolfson</u> Last   |  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>16</u> Year <u>1967</u>   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>W</u>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>9-19-14</u>   |  |
| 9. AGE (In years last birthday) <u>53</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 12. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md. N.Y.</u>  |  | 14. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 15. FATHER'S NAME <u>GUSTAV JACOBS</u>  |  | 16. MOTHER'S MAIDEN NAME <u>Ann Greenberg</u>   |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)  |  | 18. SOCIAL SECURITY NO. <u>---</u>  |  |
| 19. INFORMANT <u>Husband</u>  |  | Address <u>SAME</u>   |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u><br>DUE TO <u>Cancer of Liver</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u><br>DUE TO (c) <u>---</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>April 1967</u><br><u>July 1967</u>   |  |
| 21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 24a. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 24b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work                               |  |
| 25a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 25b. (City or town) (County) (State)  |  |
| 26. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> , 19 <u>67</u> , to <u>7-16</u> , 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>7-16</u> , 19 <u>67</u> , and that death occurred at <u>2:50 PM</u> , from causes and on the date stated above  |  |   |  |
| 27a. SIGNATURE <u>Francis V. Petrino</u>  |  | 27b. DATE SIGNED <u>7/16/67</u>   |  |
| 28a. PHYSICIAN'S NAME (Type)  |  | 28b. ADDRESS  |  |
| 29a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 29b. DATE THEREOF <u>JULY 18, 1967</u>  |  |
| 29c. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>   |  | 29d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>   |  |
| 30a. FUNERAL DIRECTOR <u>SYLVAN S. LEWIS &amp; SON, INC.</u>  |  | 30b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |
| 31a. ADDRESS <u>GARRISON MD.</u>  |  | 31b. DATE REC'D BY REGISTRAR <u>JUL 18 1967</u>   |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1982

CERTIFICATE OF DEATH

1982

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

|                                       |  |  |  |  |  |
|---------------------------------------|--|--|--|--|--|
| 1. Name of deceased: [illegible]      |  | 2. Sex: [illegible]                    |  | 3. Age: [illegible]                    |  |
| 4. Date of birth: [illegible]         |  | 5. Date of death: [illegible]          |  | 6. Place of death: [illegible]         |  |
| 7. Cause of death: [illegible]        |  | 8. Signature of physician: [illegible] |  | 9. Signature of registrar: [illegible] |  |
| 10. Date of registration: [illegible] |  | 11. [illegible]                        |  | 12. [illegible]                        |  |
| 13. [illegible]                       |  | 14. [illegible]                        |  | 15. [illegible]                        |  |
| 16. [illegible]                       |  | 17. [illegible]                        |  | 18. [illegible]                        |  |
| 19. [illegible]                       |  | 20. [illegible]                        |  | 21. [illegible]                        |  |
| 22. [illegible]                       |  | 23. [illegible]                        |  | 24. [illegible]                        |  |
| 25. [illegible]                       |  | 26. [illegible]                        |  | 27. [illegible]                        |  |
| 28. [illegible]                       |  | 29. [illegible]                        |  | 30. [illegible]                        |  |
| 31. [illegible]                       |  | 32. [illegible]                        |  | 33. [illegible]                        |  |
| 34. [illegible]                       |  | 35. [illegible]                        |  | 36. [illegible]                        |  |
| 37. [illegible]                       |  | 38. [illegible]                        |  | 39. [illegible]                        |  |
| 40. [illegible]                       |  | 41. [illegible]                        |  | 42. [illegible]                        |  |
| 43. [illegible]                       |  | 44. [illegible]                        |  | 45. [illegible]                        |  |
| 46. [illegible]                       |  | 47. [illegible]                        |  | 48. [illegible]                        |  |
| 49. [illegible]                       |  | 50. [illegible]                        |  | 51. [illegible]                        |  |
| 52. [illegible]                       |  | 53. [illegible]                        |  | 54. [illegible]                        |  |
| 55. [illegible]                       |  | 56. [illegible]                        |  | 57. [illegible]                        |  |
| 58. [illegible]                       |  | 59. [illegible]                        |  | 60. [illegible]                        |  |
| 61. [illegible]                       |  | 62. [illegible]                        |  | 63. [illegible]                        |  |
| 64. [illegible]                       |  | 65. [illegible]                        |  | 66. [illegible]                        |  |
| 67. [illegible]                       |  | 68. [illegible]                        |  | 69. [illegible]                        |  |
| 70. [illegible]                       |  | 71. [illegible]                        |  | 72. [illegible]                        |  |
| 73. [illegible]                       |  | 74. [illegible]                        |  | 75. [illegible]                        |  |
| 76. [illegible]                       |  | 77. [illegible]                        |  | 78. [illegible]                        |  |
| 79. [illegible]                       |  | 80. [illegible]                        |  | 81. [illegible]                        |  |
| 82. [illegible]                       |  | 83. [illegible]                        |  | 84. [illegible]                        |  |
| 85. [illegible]                       |  | 86. [illegible]                        |  | 87. [illegible]                        |  |
| 88. [illegible]                       |  | 89. [illegible]                        |  | 90. [illegible]                        |  |
| 91. [illegible]                       |  | 92. [illegible]                        |  | 93. [illegible]                        |  |
| 94. [illegible]                       |  | 95. [illegible]                        |  | 96. [illegible]                        |  |
| 97. [illegible]                       |  | 98. [illegible]                        |  | 99. [illegible]                        |  |
| 100. [illegible]                      |  | 101. [illegible]                       |  | 102. [illegible]                       |  |

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09356

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

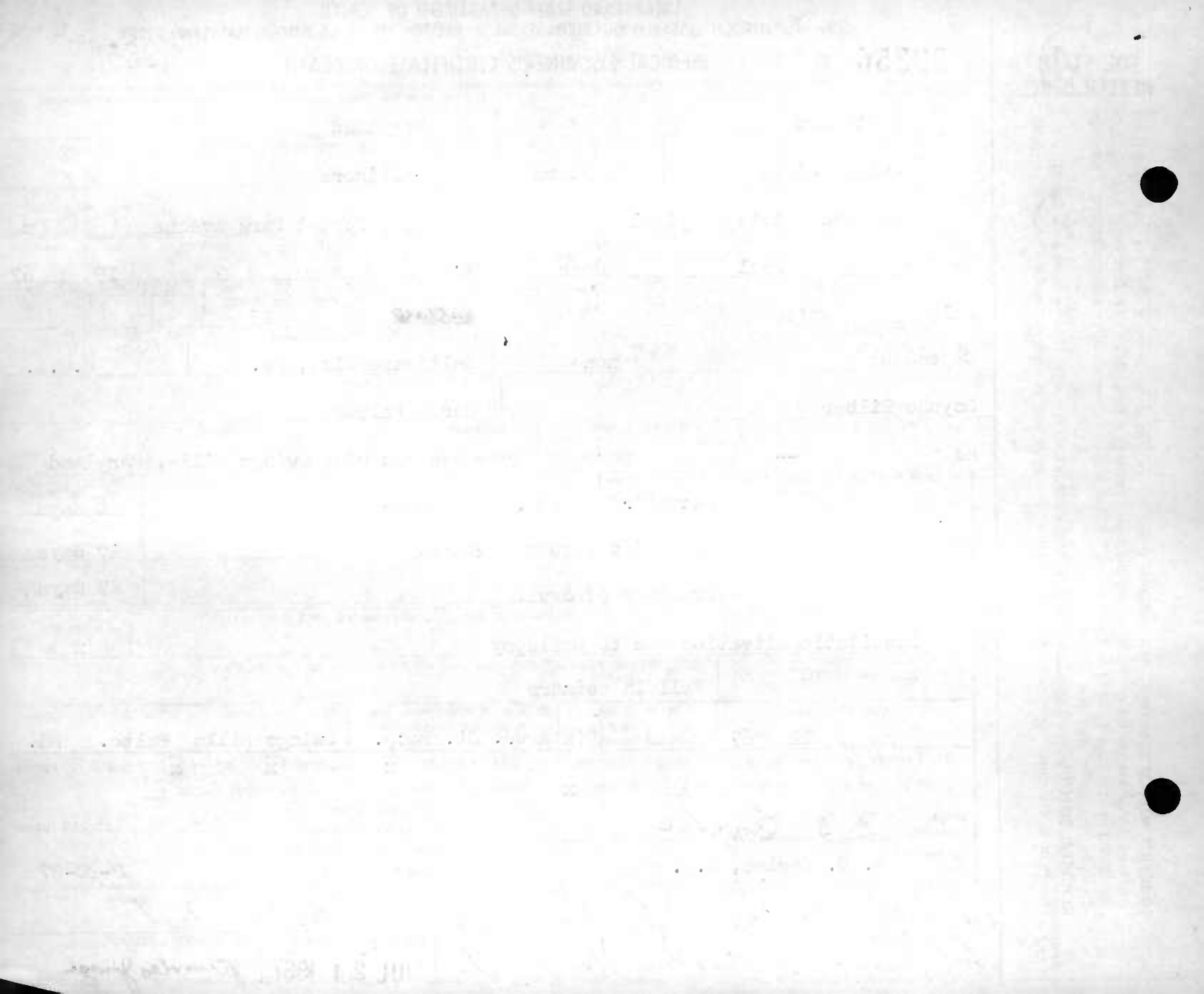
09355

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>   |                                     | c. LENGTH OF STAY IN Tb<br><b>16 years</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>  |                                     | d. STREET ADDRESS<br><b>3327 Forest Park Avenue</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joel</b> Middle <b>Noah</b> Last <b>ZILBER</b>  |                                     | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>19</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-13-42</b>  |
| 9. AGE (In years lost birthday)<br><b>25 yrs.</b>   |                                     | 10. IF UNDER 1 YEAR<br>Months <b>25</b> Days <b>19</b> Hours <b>67</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore City, Md.</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Moyshe Zilber</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Palees</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   |
| 17. INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>  |                                     | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Necrotizing Orthostatic Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Traumatic Cerebral Damage</b><br>DUE TO<br>(c) <b>Fracture of Skull</b>   |                                     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b><br><b>27 days</b><br><b>27 days</b>             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Institutionalization due to Epilepsy</b>  |                                     |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell in seizure</b>                                   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>6 22 1967</b>  |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Rswd. St. Hosp.</b>  |                                     | 20f. (City or town) (County) (State)<br><b>Owings Mills Balto. Md.</b>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                     |  |   |
| ACTUAL SIGNATURE <b>D. D. Caples</b>  |                                     | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>  |                                     | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|   |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
|   |                                     | Address (Street, city, town, or county)  |   |
| 22. DATE SIGNED<br><b>7-20-67</b>   |                                     |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>   | 23b. DATE THEREOF<br><b>7/21/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                                |
| 24. FUNERAL DIRECTOR<br><b>Sol Levinson - Bros Inc</b>  |                                     | ADDRESS<br><b>4000 1st Rd.</b>   |   |
| 25a. REC'D BY REGISTRAR<br><b>AUG 24 1967</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09357

09356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2

|   |   |  |   |
|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPH ZWOBAT</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>July 11, 1967</b>  |   |
| 3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b><br><b>BALTIMORE COUNTY</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>GARLISON Foxleigh Nursing Home</b>  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Pikesville 02-1</b><br>D. STREET ADDRESS (If rural, give location)<br><b>714 Leafydale Terrace</b>   |   |
| 5. SEX <b>M</b>   | 6. RACE <b>Caucasian</b>                              | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH <b>12-5-1890</b>   |
| 9. AGE (In years last birthday) <b>76</b>   |   | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Superintendent</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Wisconsin</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Zwobat, Stephen</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>KOSCZYNSKI, Emma</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes WW I</b>   |   | 16. SOCIAL SECURITY NO.<br><b>110-01-8086</b>  |   |
| 17. INFORMANT<br><b>Joseph W. Zwobat</b>  |   | 18. ADDRESS<br><b>714 Leafydale Terr 21208 Md.</b>   |   |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>4201</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |   | 20. CAUSE OF DEATH<br>(A) <b>Prob. Ac. Myocardial Infarction 1d</b><br>(B) <b>DUE TO</b><br>(C) <b>DUE TO</b>  |   |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT<br><b>Metastatic Carcinoma Prostate, 15 mos.</b> |   | 22. I certify that (I) (this hospital) attended the deceased from <b>31</b> <b>1967</b> to <b>7-11</b> <b>1967</b><br>that (I) <del>was</del> last saw the deceased alive on <b>7-9-67</b> <b>19</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death. |   |
| 23A. SIGNATURE<br><b>Daniel Bakal</b><br>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |   | 23B. DATE SIGNED<br><b>7-11-67</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DANIEL BAKAL, M.D.</b>   |   | 23D. ADDRESS<br>M.D. <b>3600 LOCHHEARN DR. Balto Md</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 24B. DATE<br><b>July 14, 1967</b>                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Balto National</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Fredrick Rd. Balto Md</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JUL 14 1967</b>   | 25B. NAME OF REGISTRAR<br><b>Charles J. [unclear]</b> | 25C. FUNERAL DIRECTOR<br><b>Loring Byers 8728 Liberty Rd. Randallstown Md. 21139</b>   |   |

